South Carolina Statewide Coordinated Statement of Need
January 2006

Purpose

The Ryan White Care Act Grant requires all recipients, through a representative process, to participate in the development and approval of a Statewide Coordinated Statement of Need (SCSN). The purpose of the SCSN is to provide a collaborative mechanism to identify and address significant HIV care issues related to the needs of people living with HIV/AIDS (PLWHA) and to maximize coordination, integration, and effective linkages across the Care Act Titles related to such issues. The SCSN must identify broad goals related to the needs of PLWHA, identify critical gaps in life-extending care needed by PLWHA both in and out of care, and describe cross-cutting issues for the Care Act Titles. Consistent with recent guidance received from the Department of Health and Human Services, Health Resources and Services Administration, this SCSN focuses on six core service areas: primary medical care consistent with public health service treatment guidelines, HIV related medications, mental health treatment, substance abuse treatment, oral health, and case management.

Process

This SCSN was developed collaboratively with the input of a broad spectrum of HIV/AIDS stakeholders. A full-day participatory meeting was convened with forty-one (41) participants on September 9, 2005, in Columbia, S.C., to identify the goals, needs, and strategies described in this plan. An external consultant designed and facilitated the meeting process. The table below shows the type and number of stakeholders represented at this meeting.

Stakeholder Type	Number Represented	Stakeholder Type	Number Represented
Title II	24	DHEC	9
Title III	16	ADAP	3
Title IV	5	Dept. of Corrections	1
PLWHA	1	AETC	3
Prevention	9	Housing	1
Substance Abuse	1		

Overview

The SCSN is organized into three main sections. The first section summarizes past needs assessments and epidemiological data presented at the stakeholder meeting including findings from focus groups with PLWHA, surveys with providers, expenditures by service area, and data on the incidence and prevalence of HIV infection among various sub-populations.

The second section focuses on the needs of PLWHA who are already receiving Ryan White Care Act funded services (i.e., PLWHA in care). A three-year goal is described for each service area, followed by a listing of barriers and gaps in meeting the needs of PLWHA and proposed strategies for addressing those needs. This section concludes with a description of barriers and gaps common across the six service areas.

The third section focuses on PLWHA who are out of care. Barriers to care are described followed by proposed strategies for addressing these barriers and reducing the number of PLWHA who are out of care.

I. Needs Assessment and Epidemiological Data

In 2001 Ryan White Title II providers conducted a needs assessment process that was coordinated by the Peer Review Committee and driven by HRSA guidance. The process included three elements: a consumer needs survey, a medical provider survey, and consumer focus groups.

Almost 1300 consumer needs assessment surveys were completed statewide between January and June 2002 by consumers receiving Ryan White Title II services. The findings of the survey were positive in that 83% of respondents were very satisfied with medical care, 86% were very satisfied with ADAP services and 88% were very satisfied with case management services.

In 2003 Dr. Wayne Duffus conducted a medical provider survey that focused on the training needs of urban and rural providers. Findings from the survey show that urban providers report being more comfortable that rural providers prescribing anti-retroviral therapy and discussing sexual behavior. Urban Providers also report being more familiar with anti-retroviral guidelines than rural providers. Also, urban providers reported using the Internet more frequently than rural providers.

In 2005 focus groups were conducted and supported by the Ryan White CARE Act Title II Peer Review Committee, the South Carolina HIV/AIDS Planning Council, the University of South Carolina School of Public Health (USC SPH) and the National Alliance of State and Territorial AIDS Directors (NASTAD). NASTAD conducted three (3) focus groups as part of an Office of Minority Health (OMH) project focusing on minority issues. NASTAD also facilitated training of focus group leaders and recorders. The USC SPH conducted the remaining focus groups throughout the state and conducted data analysis. Preliminary data showed 12 focus groups were conducted statewide with 113 participants. Of the participants, 107 were in-care, 4 were not in-care and 2 participants did not respond. Fifty-five individuals (49%) were female, 50% were

male and 1% transgender. Eighty-five (75%) of the individuals were African American, 23% Caucasian, 1% Native American and 1% Other. Three percent reported Hispanic ethnicity. Twenty-eight percent reported less than a high school education. Twenty-six percent were unemployed and 36% reported being on disability. Forty-nine percent report an income level less than $10,000 annually. Sixty-four percent reported having received HIV prevention services during the last year. The discussion guide encompassed the following four areas: service utilization, barriers to care and unmet needs, prevention services and testing, and consumer involvement. Overall it appeared that the amount, availability and quality of the care were specific to each service area. In each of the service areas, the term "case manager" had a different and sometimes multiple meanings, according to how the Ryan White clinic was established in their specific area. Although many responded that they truly appreciate their case manager, there was some confusion about having multiple case managers. The participants conveyed that they rely heavily on their local HIV agencies for support and they have positive perceptions of the services they receive. During the focus groups the facilitator asked the participants why they had decided to be "in care" or "out of care" at that particular time. Overwhelmingly, the participants indicated that they were in care in order to prolong their lives. The greatest barriers to care among the participants in the focus groups were associated with transportation to care, the actual treatment they received while attempting to attain care, eligibility requirements, and the limiting rules and regulations around Medicare/Medicaid. During the course of the focus group, the participants were asked about HIV prevention in their local communities, why people are not getting tested and what is needed to increase prevention services. The respondents felt as though the greatest need for prevention was among youth. The respondents indicated that people did not seek testing for three major reasons: the fear of finding out, denial that they may be HIV positive, and not wanting to experience the stigma associated with HIV. The respondents indicated that the cost of being HIV positive goes far beyond the financial hardship. The stigma and prejudice that HIV persons endure pose additional challenges including loss of job, poor treatment, and fear of persecution for their children. Short-term immediate housing, such as shelters, is also a great challenge throughout the State.

In looking at the overall needs for PLWHA in South Carolina, an estimate of care resources and numbers of PLWHA served is essential. The following are tables that indicate the numbers of PLWHA who are served by all payer sources, including the Ryan White CARE Act, and the percentages of the Ryan White funding that is spent on the six core services.

Payer Source	**Estimate of # Served in 2004***
Title II	5,399
Title III	3,488
Title IV	909
Medicaid	3,514
Private Pay	1,916-2,053

*Numbers are duplicated across providers. Private Pay estimated from hospital outpatient billing data. Title III data is incomplete.

Ryan White Core Service	**Estimate of RW Title II Resources for 2004**
Medical Care	32%
Medications	4%

Oral Health Care	2%
Mental Health Services	<1%
Substance Abuse Services	<1%
Case Management	34%

Ryan White Core Service	**Estimate of RW Title III Resources for 2004**
Medical Care*	55%
Medications	14%
Oral Health Care	4%
Mental Health Services	7%
Substance Abuse Services	<1%
Case Management	11%

*Title III currently mandates at least 50% of funding be expended for medical care.

Ryan White Core Service	**Estimate of RW Title IV Resources for 2004**
Medical Care	15%
Medications	0%
Oral Health Care	0%
Mental Health Services	3%
Substance Abuse Services	0%
Case Management	37%

Ryan White Core Service	**Estimate of Medicaid Resources for 2004**
Medical Care	26%
Medications	57%
Oral Health Care	<1%
Mental Health Services	5%
Substance Abuse Services	<1%
Case Management	Not allowable

Question #1: What are the sociodemographic characteristics of the population?

The HIV epidemic in the United States, and in South Carolina, is a composite of multiple, unevenly distributed epidemics in different regions and among different populations. These populations may comprise persons who practice similar high-risk behavior, such as injecting drugs or having unprotected sex with an infected person. Although race and ethnicity are not risk factors for HIV transmission, they are markers for complex underlying social, economic, and cultural factors that affect personal behavior and health. Low socioeconomic status is associated with increased disease morbidity and premature mortality. Unemployment status is correlated to limited access to health care services, resulting in increased risk for disease. This section provides background information on South Carolina's populations and contextual information, i.e. education, poverty level, housing, etc, for assessing potential HIV impact. The social, economic, and cultural context of HIV infection must be considered when funding, designing, implementing and evaluating HIV prevention programs for diverse populations.

The State

South Carolina lies on the southeastern seaboard of the United States. Shaped like an inverted triangle, the state is bounded on the north by North Carolina, on the southeast by the Atlantic Ocean, and on the southwest by Georgia. It ranks 40th among the 50 states in size and has a geographic area of 30,111 square miles. South Carolina has a diverse geography that stretches from the Blue Ridge Mountains in the northwest corner to the beaches along the Atlantic coast in the southeast. There are 46 counties and they are divided into 8 public health regions. Columbia, located in the center of the state, is the capital and the largest city. There are 3 metropolitan areas with a population of 500,000 or more: Columbia, Charleston and Greenville areas. The state is crisscrossed by interstate highways that link it with every part of the country, including I-95 extending north-south across the center of the state from New York to Florida and I-26 from Asheville, North Carolina to Charleston, South Carolina, and I-20 that extends east-west across the state from Florence, South Carolina to Atlanta, Georgia. Manufacturing is the state's leading industry, followed by tourism and forestry.

Populations

Based on projected population estimates, in 2003, the total number of South Carolinians was 4,147,152. Of this total, 67.2% were Caucasian, 29.5% were African American, 0.3% was Native American, 0.9% was Asian and Pacific Islander, and 2.4% were of Hispanic origin. Fifty-one percent were female and forty-nine percent were male (percentages based on 2000 data). Seventy-two percent of the population distribution in South Carolina is defined as metropolitan, 29% is non-metropolitan. The proportion of persons who have completed a bachelor's degree or more is 20.4, lower than the U.S. proportion of 24.4. (Figure 2)

Figure 2: Selected Demographic Information South Carolina and United States, 2000

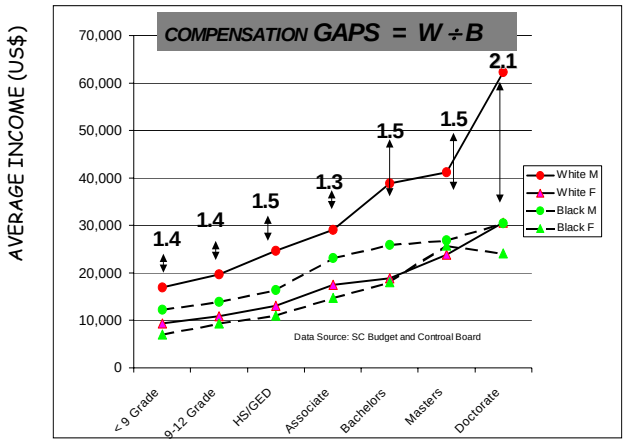
	South Carolina	United States
Population (2000)	4,012,012	281,421,906
Pop. Density (persons/square mi.)	133.2	79.6
Median Age	35.4	35.3
Racial/Ethnic Distribution of Pop.		
% White	67.2	75.1
% Black	29.5	12.3
% Asian/Pacific Islander	0.9	3.6
% Amer.Ind/Alaskan Nat.	0.3	0.9
% Hispanic	2.4	12.5
Educational Attainment (Age ≥25yrs)		
High school grad. +	76.3	80.4
Bachelor's degree +	20.4	24.4

Source: U.S. Bureau of the Census,2000

Education & Earnings

Despite the economic strides it has made in recent years, South Carolina remains among the states with the highest percentage of persons who live below the poverty level (15th of fifty states and District of Columbia). Educational attainment is strongly correlated with poverty, and South Carolina continues to rank low in percent of persons over 25 years of age who have bachelors' degrees or higher (36th of fifty states and District of Columbia). Nearly twenty percent (19.2%) of the population has less than a high school education.

Figure 3: Income by Educational Attainment by Race & Gender: SC, 1990



Educational attainment and earnings are directly related. The more education a South Carolinian has, the more money he/she is likely to earn. However, if we compare across gender and racial lines, there are inconsistencies.

White males clearly attain the highest incomes. The income gap between whites and blacks is higher for each education level, but particularly increases for persons with bachelors degrees or more. Income for whites is 1.5 times greater than blacks for persons with bachelors and masters degrees, and is 2.1 times greater than blacks for persons with doctorates. (Figure 3)

Figure 4: SC Per Capita Income in 1999 by Race and Hispanic Origin

INCOME GAPS		Rel to Blacks
• For Whites	$22,095	**1.9**
• Native Hawaiian/ Other Pacific Islander	$21,638	**1.8**
• For Asian	$20,541	**1.7**
• For American Indian/ Alaskan Native	$15,325	**1.3**
• Of Hispanic Origin	$12,143	**1.0**
• For Other Races	$10,473	**0.9**
• For Blacks	$11,776	**1.0**
• OVERALL	$18,795	**1.6**

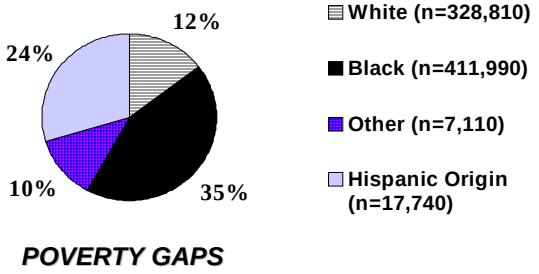
Data Source: SC-Budget & Control Board, Office of Research & Statistics

In comparison, Blacks, people of Hispanic origin, and other races earned the least per capita income, averaging 39% below the state's average. Whites earned 18% above the state's average per capita income. (Figure 4)

Poverty Level

Based on 2000 Census data, approximately 13.4% of South Carolinians lived below the poverty level (ranking 17th in the US); and 10.7 % of South Carolinian families lived below the poverty level (ranking 12th in the US).

Figure 5: Percent of Each Racial/Ethnic Pop Living Below Federal Poverty Level; SC, 2002-2003



POVERTY GAPS

Thirty-five percent of Black South Carolinians were below poverty in 2002-2003, compared to 24% of persons of Hispanic descent, 12% among Whites and close to 10% of persons categorized as other, which includes Asian, Pacific Islanders, and Native Americans. (Figure 5)

Data Source: SC-Budget & Control Board, Office of Research & Statistics

Insurance/Access to Primary Care

Thirteen percent (13%) of South Carolinians do not have health insurance coverage. A significantly higher proportion of persons in the state do not have access to a primary care provider (35.8%) compared to the total U.S. population (17.1%). (Figure 6) Over 95% of counties are designated all or part medically underserved areas and all or part health profession shortage areas (1999).

Figure 6: Selected Access Indicators, SC and US

	SC	US
Total Pop. Uninsured, 2002-2003	13.4%	15.4%
Below 200% Poverty Level, 2003	33.7%	31.1%
Counties Designated All/Part Medically Underserved Areas, 1999	95.7%	80.5%
Without Access to Primary Care Provider, 1996	35.8%	17.1%
Women Receiving 1st Trimester Prenatal Care, 2000	79%	83%

Source: U.S. Dept. of Health and Human Services, HRSA

Employment

South Carolina's average unemployment rate for 2004 was 6.8%, slightly higher than the US rate of 5.5%. The median income in 2002 was $37,442 vs. the US median income of $42,409.

Housing

According to the US Census 2001 Supplemental Survey, 71% of the state's homes are owned. The SC Dept. of Commerce estimates that 12,410 persons may be homeless at some point in time.

Summary

South Carolina, as many southern states, ranks high for poverty, low educational attainment, and uninsured population compared to other US states. These factors can affect one's ability to access prevention and health care services and adhere to regimens for treatment and care of diseases that may lead to more severe consequences.

Question #2: What is the impact of HIV/AIDS on the population?

In the United States, HIV/AIDS remains a significant cause of illness, disability, and death, despite declines in new AIDS cases and deaths from 1995 to 2004. Current surveillance provides population-based HIV/AIDS data for tracking trends in the epidemic, targeting and allocating resources for prevention and treatment services, and planning and conducting program evaluation activities.

In South Carolina, AIDS cases have been reported since 1981, and confirmed cases of HIV infection have been reportable since February 1986. During the calendar year of 2003, according to the CDC HIV/AIDS Surveillance Report, South Carolina ranked 9th among states and the District of Columbia with an AIDS case rate of 18.7 per 100,000 population. During this same time period, South Carolina also ranked ninth among states and the District of Columbia with an AIDS case rate of 14.2 per 100,000 for female adolescent/adult AIDS cases. The epidemic is continuing to grow with an average of 75 cases of HIV infection reported each month during the past year. As of December 31, 2004, there were 20,263 persons cumulatively reported with HIV, and of them, 14,340 have been diagnosed with AIDS.

South Carolina has experienced a 79% increase of all persons living with HIV/AIDS from 1995 to 2004. More dramatic, there has been over a 100% increase in the number of women living at the end of 2004 compared with the number living in 1995.

This section summarizes the overall toll of the epidemic in South Carolina based on total reported HIV/AIDS cases and deaths.

Gender

Figure 7 shows the impact of HIV on the men and women in South Carolina. Men unequivocally are disproportionately affected by HIV/AIDS. They make up 49% of South Carolina's total population, but comprise 69% of persons living with HIV (prevalence). HIV-only diagnosed cases during the two-year period 2002-2003 gives an estimate of more recent infections or potentially emerging populations. These data show an increasing proportion among females (38%) compared to the prevalence data (31%).

Figure 7: Disproportionate HIV Impact by Gender, South Carolina

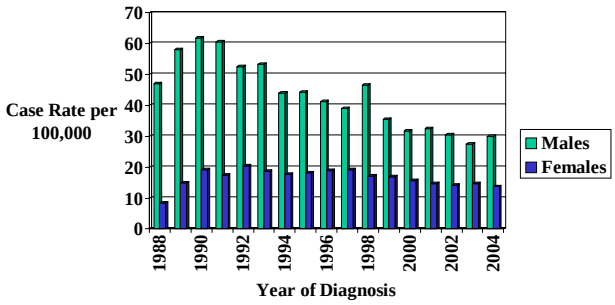
SEX	No.(%) SC Total Population	No. (%) of Total Estimated Living With HIV/AIDS, 2004	No. (%) of Total HIV-Only Diagnosis, 2002-2003
Male	1,948,929 (49%)	9,466 (69%)	606 (62%)
Female	2,063,083 (51%)	4,215 (31%)	366 (38%)
Total	4,012,012	13,681 (100%)	972 (100%)

Source: 2000 US Census Data; SCDHEC HARS

Note: The estimated number of persons living with HIV/AIDS as of 2001 includes 1,310 persons reported to other states upon initial diagnosis but who have subsequently moved to South Carolina and received care. Persons who had only an HIV infection diagnoses (not yet AIDS) during 2002 – 2003 includes only persons initially diagnosed and residing in South Carolina and excludes any out-of-state cases who may have moved to the state.

Figure 8 shows the rate per 100,000 population for males and females diagnosed with HIV/AIDS each year. During 1996 – 2004 the case rate for females appears to be slightly decreasing. For males, the rate had declined prior to 1998, when the rate increased due to screening in the state correctional facilities. With the exception of 1998, the ratio of men to women has averaged about 2 to 1 during the past three years, where previously it was more than 3 to 1.

Figure 8 : HIV/AIDS Case Rate per 100,000 for Males and Females, 1988 - 2004



Race/Ethnicity

African Americans are disproportionately impacted by HIV/AIDS in South Carolina. They comprise 30% of the state's total population, yet 73% of the total persons living with HIV are African American. Two percent (2%) of total cases are Hispanic, who comprise the same proportion of the state's population (Figure 9).

Figure 9: Proportion of Persons Living with HIV/AIDS by Race/Ethnicity, 2004

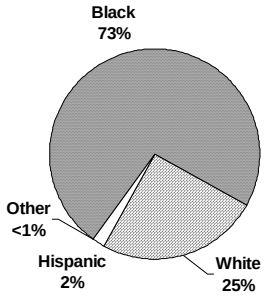
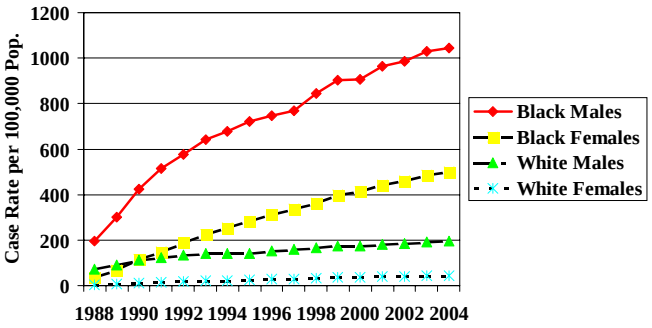


Figure 10: Disproportionate HIV Impact by Race/Ethnicity/Gender, SC

Gender & Race/Ethnicity	No. (%) SC Total Pop.	No. (%) of Total Persons Living With HIV/AIDS, 2004	No.(%) of Total HIV Only Diagnosis, 2002-2003
Black Males	593,707 (15%)	6487 (47%)	429 (48%)
Black Females	668,799 (17%)	3517 (26%)	295 (29%)
White Males	1,355,222 (34%)	2744 (20%)	155 (15%)
White Females	1,394,284 (35%)	622 (5%)	55 (6%)
Hispanic Males	23,978 (0.6%)	201 (1.5%)	18 (1.7%)
Hisp. Females	22,296 (0.6%)	53 (0.4%)	4 (0.4%)

African American men comprise 15% of the state's population, yet 47% of the total prevalent HIV/AIDS cases in 2004. African American women, similarly, comprise 17% of the population, yet 26% of prevalent cases. More recent infections (HIV-Only Diagnosis) during 2002 - 2003 reflect a slight decrease among white men and increase among African American women relative to the proportion of persons living with HIV in 2004. (Figure 10)

Figure 11: HIV/AIDS Prevalence Rates by Race/Gender, SC

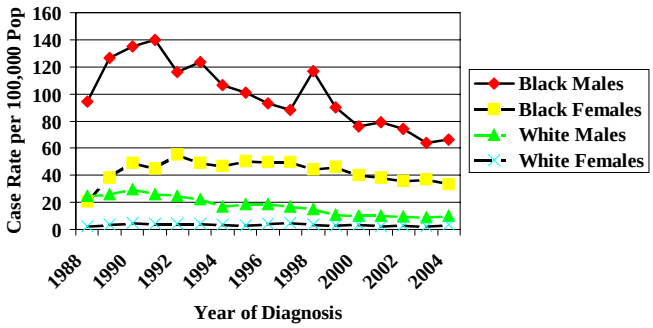


Each year the number of all persons living with HIV/AIDS continues to grow. Case rates per 100,000 by race and gender show the disparate burden of HIV among African Americans. As Figure 11 shows, the rate per 100,000 population in 2004 is five times higher for black males than for white males, and twelve times higher for black females compared to white females. An increase in the case rate for black men in 1998 reflected a large number of new cases reported as a result of a Department of Corrections screening.

While the overall number and rate of newly diagnosed persons with HIV/AIDS each year is stable, there are differences among race/gender populations. (Figure 12) The case rate per 100,000 population among white men in South Carolina has on average remained relatively stable during the past five years (2000-2004). The increasing rate among African American women in both S.C. and the U.S. during 1988 - 1992 indicate the increasing risk of heterosexual transmission. Recently, the rate for African American women in S.C. decreased 17% from 2000 to 2004.

As stated previously, the case rate among African American males increased in 1998-1999 due to correctional facility screening; however, overall the rate decreased 13% during the past five years.

Figure 12: HIV/AIDS Case Rates by Race/Gender and Year of Diagnosis, SC



Age

When looking at age groups, persons between the ages of 20 and 44 are disproportionately impacted. They make up 37% of the total population yet they represent about 80% of prevalent and 73% of HIV-only diagnosed cases. (Figure 13)

Figure 13: Disproportionate HIV Impact by Age, SC

Age	No. (%) SC Population	No. (%) of Total Persons Living with HIV/AIDS, 2004	No. (%) of Total HIV-Only Diagnosis, 2002-2003
< 13 Years	724,209 (18%)	148 (1%)	5 (.5%)
13 – 19 Years	411,579 (10%)	450 (3%)	51 (5%)
20 – 44 Years	1,467,669 (37%)	10,914 (80%)	708 (73%)
45+ Years	1,408,565 (35%)	2,198 (16%)	208 (21%)

Figure 14: S.C. HIV/AIDS Case Rate per 100,000 by Age by Year of Diagnosis, 1988-2004

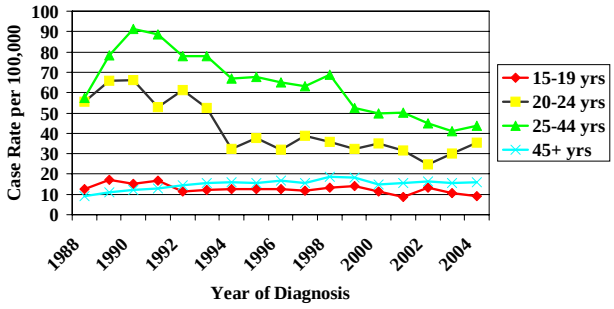
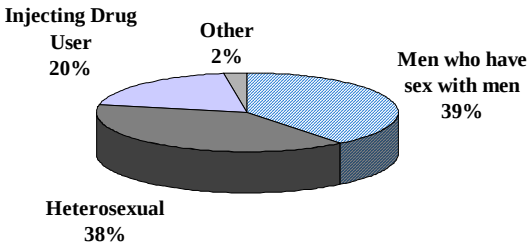


Figure 14 shows the HIV/AIDS case rates per 100,000 population by year of diagnosis for selected adult/adolescent age groups for the past seventeen years. The rates are highest for persons 25 - 44 years of age, followed by those 20 –24 years.

Risk Exposure

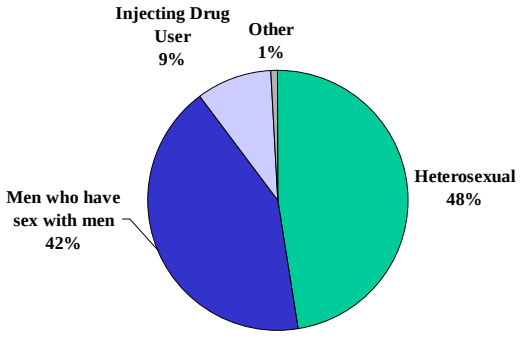
Men who have sex with men (MSM) comprise the greatest proportion of persons living with HIV/AIDS at the end of 2003 with known risk factors (39%), followed closely by heterosexuals (38%). Twenty percent (20%) are injecting drug users. (Figure 15). Other risks include blood transfusions, hemophilia, perinatal transmission. Of the total estimated number of persons living with HIV/AIDS in 2003, 25% had no risk identified (not reflected in Figure 15).

Figure 15: Proportion of Persons Living with HIV/AIDS by Risk Exposure, 2004 N=10,340



Note: Total Excludes Cases with No Risk Identified

Figure 16: Proportion of HIV/AIDS Cases by Risk Exposure, 2003-2004 N= 1,170



Note: Total Excludes Cases with No Risk Identified

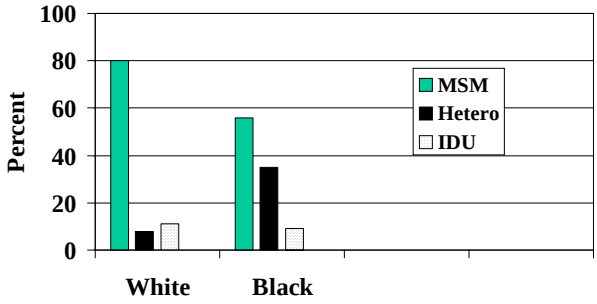
Figure 16 shows a slight shift in risk exposure categories among persons diagnosed with HIV/AIDS during 2002 – 2003 with known risk exposures compared to the prevalent cases in Figure 15. The proportion of cases due to heterosexual transmission was 51%, men who have sex with men accounted for 38%. Thirty-six percent (36%) of these cases had no risk identified (not reflected).

Note: The primary reasons for risk exposure information not reported were explained in the Introduction, South Carolina HIV/AIDS Surveillance System section. Over time, the proportion of cases with no risk identified in a given year decreases when risks are determined through follow-up surveillance activities. For example, during 2000 there were 312 cases originally reported with no risk; as of December 2001, risks were determined for 249 of the 312 cases. The race/gender profile of 2004 cases originally reported with no risks is similar to the total proportion of HIV/AIDS cases by race/gender (Figure17).

Figure 17: Comparison of No Risk Identified Cases with Total S.C. HIV/AIDS Reported Cases, 2004

Race/Gender (Adult/Adolescent Cases)	% Total Cases with No Risk Identified, 2004 N=301	% Total HIV/AIDS Cases Reported, 2004 N=897
Black Male	45%	46%
Black Female	30%	26%
White Male	9%	16%
White Female	6%	5%
Other	10%	7%

Figure 18: Proportion of White and Black Male HIV/AIDS Cases By Exposure Category, Diagnosed 2003-2004

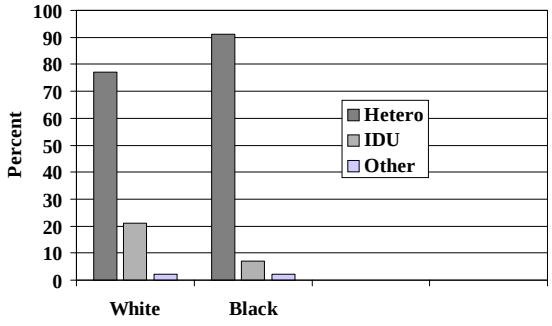


Total Males, All Ages; Excludes Persons with No Risk Reported; N=786

During 2003 – 2004, 70% of males diagnosed with HIV/AIDS were African American. Among African American males with reported risk factors, most cases were attributed to male to male sexual contact (56%) and heterosexual contact (35%). Injecting drug use was reported more frequently among white men (11%) than African American men (9%). Among white men, 80% were men who have sex with men. Only 8% reported heterosexual risk. (Figure 18)

Among women diagnosed during 2003 – 2004, 82% of cases were among African American women. Heterosexual contact was the most common reported risk for all women (90%). Injecting drug use is more commonly reported among white women (21%) than among black women (7%). (Figure 19)

Figure 19: Proportion of White and Black Female HIV/AIDS Cases By Exposure Category, Diagnosed 2003-2004



Total Females, All Ages; Excludes Persons with No Risk Reported; N=365

Figures 20 and 21 show the proportion of total HIV/AIDS cases diagnosed during four periods from 1993 – 2004 by sex and risk exposure category for males and females in South Carolina. Both men and women experienced decreases over time in the proportion of total cases with risk reported among injecting drug users. There was a 58% decrease in the proportion among injecting drug use for both men and women during 1993 – 1995 to 2002 – 2004. The proportion of heterosexual risk increased 70% for men and increased 20% for women during the same time periods.

Figure 20: Proportional Distribution of Male HIV/AIDS Cases, by Exposure Category, Diagnosed 1993-2004

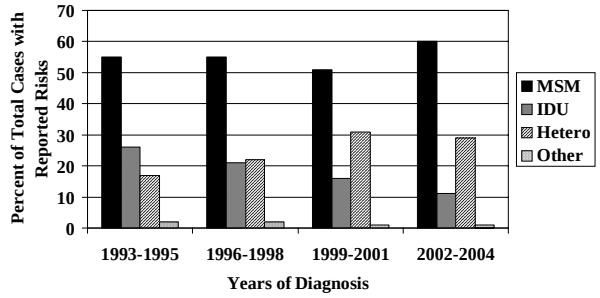
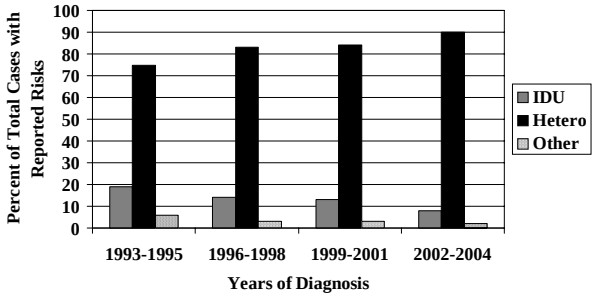


Figure 21: Proportional Distribution of Female HIV/AIDS Cases, by Exposure Category, Diagnosed 1993-2004



Residence

Persons living with HIV/AIDS are widespread throughout the state. Over 57% of counties have prevalence rates >600 per 100,000 for African Americans, as reflected in Figure 22. Annual case rates in counties of more recently diagnosed African American persons during 2002 – 2004 reflect essentially the same counties as highest prevalence rates. Richland county has the highest annual case rate (Figure 23).

Figure 22: SC HIV Prevalence Rates (per 100,000 population)Cases Currently Living, 2004 African-American

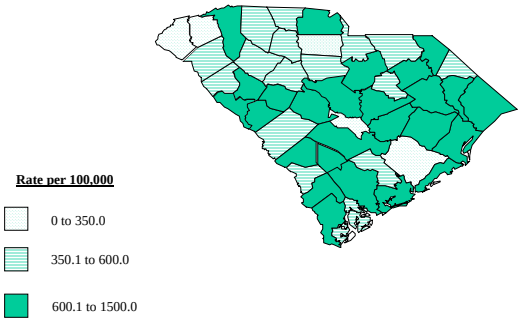
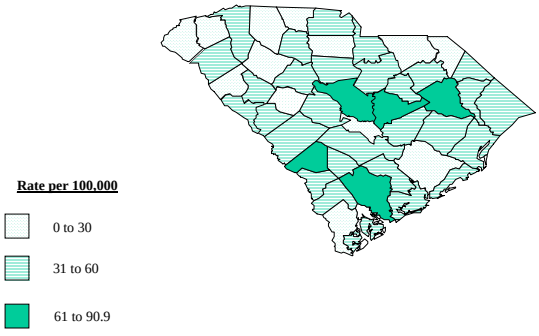


Figure 23: SC HIV/AIDS Incidence Rates (per 100,000 population) 2002-2004 Average of Cases African-American



Counties with highest prevalence rates among white persons include more urban areas of Greenville, Spartanburg, Richland and Lexington (Columbia), Charleston, Horry (Myrtle Beach), as well as Orangeburg, Sumter, Florence, Marlboro, Dorchester, Fairfield, Jasper, Allendale, McCormick, Colleton, and Lee (Figure 24). Figure 25 shows counties with highest rates of more recently diagnosed white persons are Richland, Charleston, Horry, Newberry, Fairfield, Lee, Bamberg, and Barnwell.

Figure 24: SC HIV Prevalence Rates (per 100,000 population)Cases Currently Living, 2004 Whites

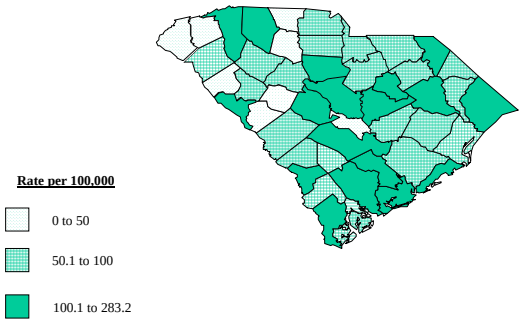
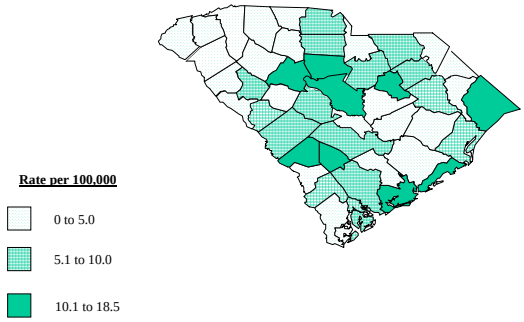


Figure 25: SC HIV/AIDS Incidence Rates (per 100,000 population) 2002-2004 Average of Cases Whites

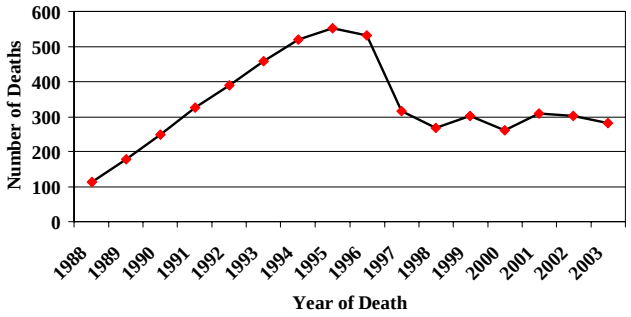


Mortality

With the advent of combination therapies and the use of prophylaxis, persons infected with HIV are living longer, delaying the progression of AIDS, which is the advanced stage of the disease. These medications have also led to the decrease in HIV-related deaths.

Large declines in HIV mortality nationally essentially occurred during 1996 – 1997. Officials at the Centers for Disease Control and Prevention (CDC) cautiously attributed the sudden drops in deaths to new anti-retrovirals, protease inhibitors, combination therapies, and increased prophylaxis for opportunistic illnesses. However, the initially reported gains were tempered by reports of demographic differentials that suggested only certain groups were benefiting from these new therapies

Figure 26: Deaths Among Persons with AIDS in South Carolina, 1988-2003



Source – SCDHEC, Vital Records, SC Residence Data

Figure 26 shows largest declines in deaths in South Carolina were in 1997, dropping to 317 from 532 the previous year. In recent years, death among persons with AIDS has remained fairly stable, which may indicate diminishing efficacy of therapies among some patients. Reasons for this may include delay in diagnosis of HIV infection until severe symptoms arise, difficulty in adherence to prescribed medical treatments, and development of viral resistance to therapy.

Figure 27: Characteristics of Persons who died of AIDS, 2003

	No.	%
Race/Sex		
Black Male	143	51
Black Female	79	28
White Male	41	15
White Female	16	6
Age Group		
<15	---	0
15-24	5	2
25-44	161	58
45+	111	40

Although black males represent 48% of persons living with HIV/AIDS, in 2003, they accounted for the majority of persons dying from AIDS (51%). African American females accounted for 28% of AIDS related deaths followed by white males (15%). By age group, the majority of deaths occurred among persons 25-44 years (58%). (Figure 27)

Figure 28: Number of Persons who died of AIDS by Health Region, 2003

Health Region	No.	%
Region 1	23	8
Region 2	38	14
Region 3	81	29
Region 4	42	15
Region 5	28	10
Region 6	15	5
Region 7	36	13
Region 8	17	6

Region III and Region IV represent the highest number of deaths from AIDS in South Carolina in 2003 (Figure 28). These areas are also among those that have the highest prevalence of AIDS in the state.

Question #3: Who is at risk for becoming infected with HIV?

The persons most likely to become infected with HIV are those who engage in high-risk behaviors with persons in communities with a high number/rate of persons living with HIV infection, i.e. prevalence. As mentioned previously, growing numbers of people with HIV in South Carolina are living more healthy lives, including sexual activity. The frequency of high-risk behavior combined with the HIV prevalence in sexual or drug using-networks determines a person's risk for becoming infected. In order to accurately target STD/HIV prevention and treatment activities, it is important for community planning groups (and program providers) to have information on the number and characteristics of persons who become newly infected with HIV and persons whose behaviors or other exposures put them at various levels of risk for STD and HIV infection. This section summarizes HIV infection among population groups at high risk for HIV infection, sexually transmitted disease data, and behavioral data.

Characteristics of HIV/AIDS in Persons at Highest Risk

Analysis of characteristics of persons with HIV/AIDS helps identify persons at greatest risk for becoming infected. Risk for infection can be determined by assessing the frequency of high-risk behavior (e.g., unprotected sex, needle-sharing) in combination with the estimated prevalence of HIV/AIDS and incidence of HIV/AIDS.

Figure 29 shows the number of persons in South Carolina living with HIV/AIDS at the end of each year by reported risk. Men who have sex men (MSM) comprise the greatest number of living persons, followed by heterosexuals. Injecting drug users (IDU) and other risks (e.g. hemophilia, blood transfusion, perinatally acquired infection) comprise fewer numbers.

While men who have sex with men comprise the greater proportion of persons living with HIV, newly diagnosed HIV/AIDS cases each year indicate that beginning in 1997, more persons report heterosexual risk than male to male sex, except for 2004 where the number reporting heterosexual risk and male to male sex were almost equal. While not validated, many local experts believe that the number of heterosexuals among African American men may be artificially high due to fears of discrimination; therefore, men do not reveal male to male sex as a risk behavior. The number of injecting drug users reported each year has been steadily decreasing (Figure 30).

Figure 29: Number of Persons Presumed Living with HIV/AIDS at End of Year by Risk, 1993-2004

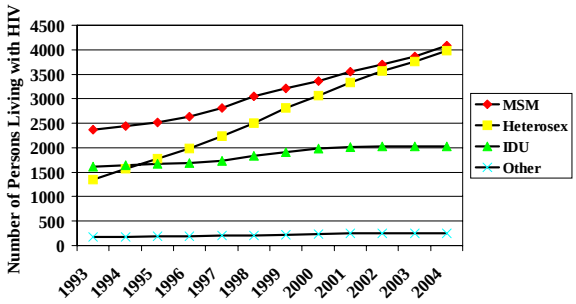
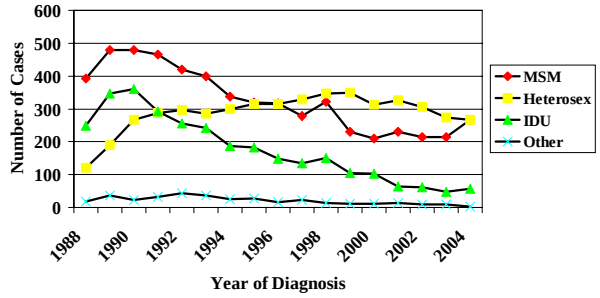


Figure 30: Number of HIV/AIDS Cases by Year of Diagnosis and Risk, 1988 -2004



Excludes Persons with No Risk Reported

Based on data in this profile, the following primary populations have been identified as being the highest risk of HIV/AIDS: men who have sex with men (MSM), high-risk heterosexuals, and injecting drug users (IDUs). Women will be described in the heterosexual and injecting drug user section, and teenagers/young adults will be described within each population category. Since African Americans are disproportionately impacted across each risk category, this impact will be described for each risk population rather than as a separate population. Infants and children and prison populations will be described separately.

Men Who Have Sex With Men

Estimates of Men Who Have Sex with Men Behavior in South Carolina

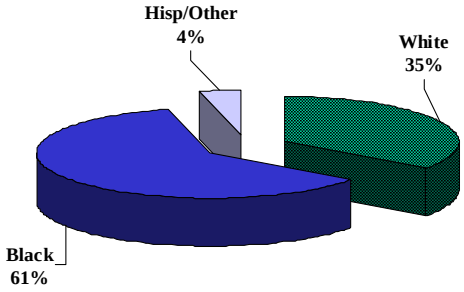
According to the U.S. Census Bureau, there are approximately 1,374,000 males in South Carolina between the ages of 15-64, which is the age range when persons are most sexually active. Review of literature and other state profiles, indicates that the estimated percentage of men who have sex with men (MSM) ranges from 2.1% to 10.1%, with the average at 2.7%. This would mean that the number of MSM in South Carolina could be estimated to be 37,098, although the estimated range is much broader.

Characteristics

Note: for purposes of this analysis, cases that are both men who have sex with men (MSM) and injecting drug users (IDU) are included in the injecting drug user category.

The largest proportion of persons living with HIV/AIDS in South Carolina at the end of 2004 was men who have sex with men (40% of total prevalent adult/adolescent cases with identifiable risk). MSM's account for a slightly higher proportion (42%) of the more recently diagnosed adult/adolescent cases during 2003-2004. The number of MSM cases diagnosed each year increased 19% from 2000 to 2004.

Figure 31: Proportion of Men with HIV/AIDS Who Have Sex With Men by Race/Ethnicity, Diagnosed 2003-2004
N=492

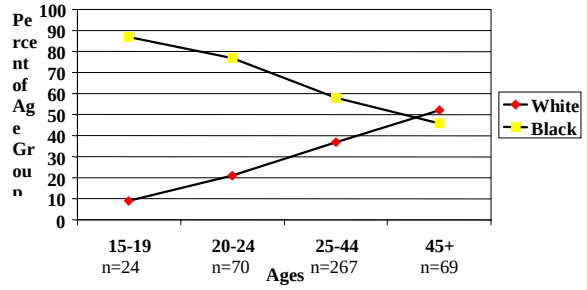


As Figure 31 demonstrates, the majority of MSM cases diagnosed during 2003 - 2004 were African Americans (61%). White men accounted for 35% of the new cases and 4% were Hispanic or other races.

The majority of men who have sex with men diagnosed during 2003 – 2004 were 25 – 44 years of age (62%); 19% were 20 – 24 years old and 14% were 45+ years. For men more recently diagnosed, African Americans accounted for the highest proportion for each age group except for those 45 and older (Figure 32).

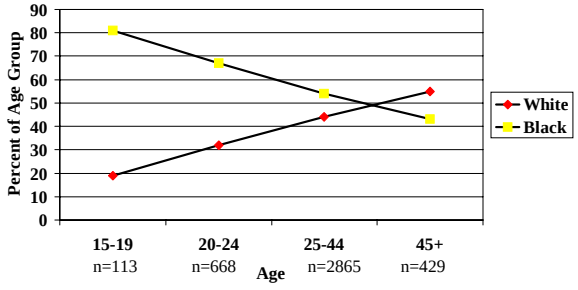
Of the men who have sex with men presumed living with HIV in 2004, 56% were African American, 42% were white and 2% were Hispanic/other men. As Figure 33 shows, for each younger age category less than 45 years, African Americans comprise the greatest proportion of living MSM's. However, among those 45 years and older, the largest proportion are white men (55%).

Figure 32 : Percent MSM HIV/AIDS Cases Diagnosed 2003-2004 by Age Group & Race N=492



Total N includes 22 Other Men Not Included in Graph Due to Small Numbers

Figure 33: Percent of MSM Living with HIV/AIDS by Age Group & Race, 2004 N=4,079

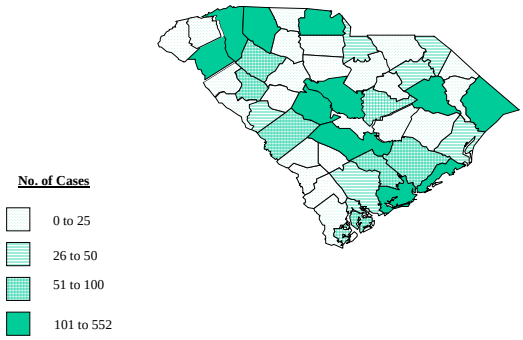


Total N includes 82 Other Men Not Included in Graph Due to Small Numbers

The more urban counties of Greenville/Spartanburg, Anderson Richland, Lexington, Charleston, Horry, Florence and Orangeburg have the greatest number of men who have sex with men living with HIV/AIDS in 2004 (Figure 34).

Due to small numbers for many counties, portraying the three-year annual case numbers of men who have sex with men by county is not useful.

Figure 34: SC HIV Prevalence by Exposure Category, 2004 Reported Cases, by County MSM



Conclusions

These data indicate that prevention efforts targeted to men who have sex with men need to be tailored to both African American and white men. African American men account for over half the proportion of both living cases (56%) and newly diagnosed HIV/AIDS cases (61%). Increased efforts in particular are needed to reach younger African American MSM <25 years of

age; for white men, targeted efforts are needed for those >25 years. Interventions also need to be particularly available for persons living in the more urban areas of the state.

High Risk Heterosexuals

Estimates of High-Risk Heterosexual Behavior in South Carolina

It is difficult to make an assessment of the number of persons in South Carolina who engage in heterosexual contact that puts them at high risk for becoming infected with HIV. While there are some differences in the population of persons with HIV/AIDS than for those with a sexually transmitted disease, most experts acknowledge that a diagnosis of an STD would suggest that the individual is engaging in unsafe sexual practices. During 2004, 20,116 cases of chlamydia, 9,588 cases of gonorrhea and 108 cases of infectious syphilis were reported in South Carolina. Women with an STD, in particular, indicate high-risk heterosexual activity. Among the 2004 cases of chlamydia, 9,980 were among women, and 3,269 women were reported with gonorrhea. More data on STDs, as well as other behavioral indicators such as teenage pregnancy and condom use is described later.

In order for a case of HIV or AIDS to be considered as heterosexual transmission, it must be documented that the individual had heterosexual contact with a person who has documented HIV infection or AIDS, or had heterosexual contact with a person who is in a high risk group for HIV (MSM or injecting drug user).

Characteristics of High Risk Heterosexuals

Persons with documented high-risk heterosexual contact comprise 38% of the total adult/adolescent persons living with HIV/AIDS at the end of 2004 and 48% of persons more recently diagnosed during 2003-2004 (excluding persons with no risk identified for both new and prevalent cases). The number of heterosexual cases diagnosed each year decreased 39% from 1999 to 2004 (Figure 30).

Figure 35: Proportion of Heterosexual HIV/AIDS Cases by Race/Sex, Diagnosed 2003-2004 N=557

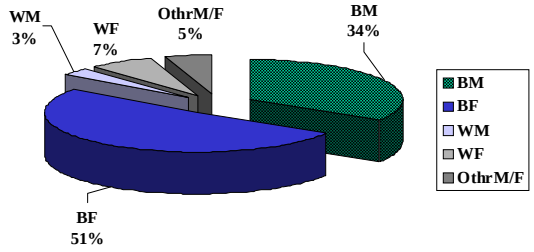


Figure 35 shows that over half (58%) of recently diagnosed heterosexual HIV/AIDS cases are women. African American women account for 51% of recent cases and white women account for 7%. Thirty-four percent (34%) are African American men. White men account for only 3% of recent cases.

Figure 36 shows the increasing number of heterosexually acquired HIV in women in South Carolina from 1988 to 2004. The proportion of female to male cases during most of this period averaged 2 to 1. The number of women has remained fairly stable during the last three years. The number of men reporting heterosexual HIV risk has

Figure 36: Number of HIV/AIDS Cases Attributed to Heterosexual Transmission, By Sex and Year of Diagnosis

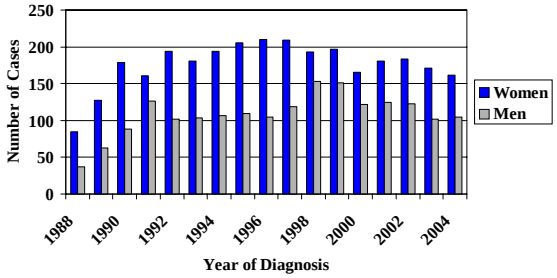


Figure 37: Percent Heterosexual HIV/AIDS Cases Diagnosed 2003-2004 By Age Group and Race/Sex N=557

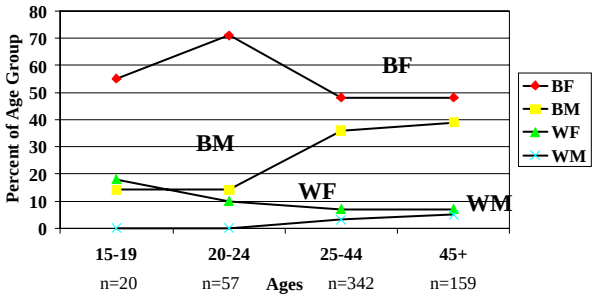
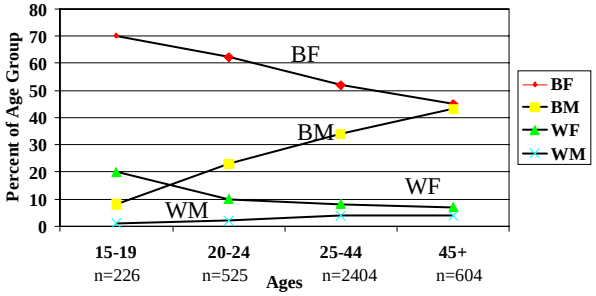


Figure 38: Percent of Heterosexuals Living with HIV/AIDS by Age Group and Race/Sex, 2004 N=3,980



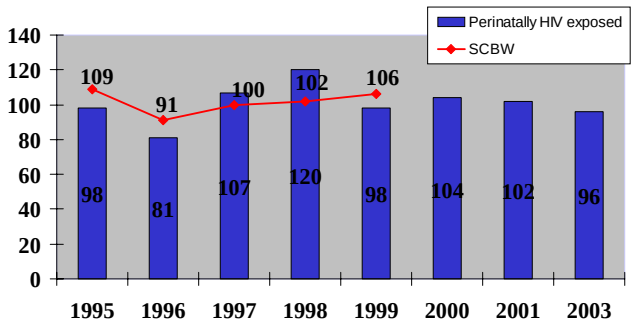
Estimates of prevalence of HIV among High Risk Heterosexual Women

Estimates of HIV prevalence among women were obtained during 1990 – 1997 through a population-based seroprevalence survey of women who deliver live births at hospitals throughout the state. Recently estimates are obtained by the pediatric surveillance system using reports of HIV infected women delivering live births. While this prevalence is limited to child-age bearing women who have delivered a gradually decreased by 30% from 1999 to 2004.

The majority of high risk heterosexuals recently diagnosed were 25 – 44 years of age (57%); 27% were 45 years and older, and 15% under 25 years. With the exception of the 15-19 year old group, African American women and men comprised the greatest proportion of cases in each age group (Figure 37). Among young women less than 45 years of age, over 8 out of every 10 of the total cases are African American women. White women and men account for an average of 9% or less of young and older ages.

Of the high risk heterosexual persons presumed living with HIV/AIDS in 2004, over half were African American women (53%), 33% were African American men; 8% were white women. As Figure 38 shows, over 8 of every 10 young women under age 25 living with HIV/AIDS were African American; over one half of persons 25 – 44 are African American women. Similarly, the proportion of persons living 45 years and older is greatest for African American women followed closely by African American men. As with more recently diagnosed persons, white women and men account for an average of 12% of persons living with HIV across all age groups.

Figure 39: Estimated HIV Prevalence Among Child-Bearing Aged Women - Perinatally HIV Exposed Births by Year of Birth Compared to Survey of Child Bearing Women

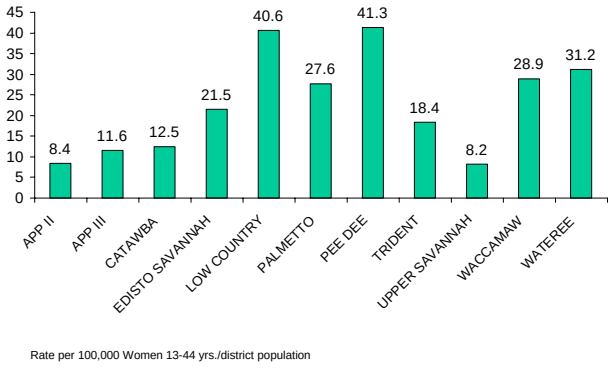


Source: provisional SC STD/HIV Program Surveillance Data

child, it provides the best overall estimate available for HIV infection among women 15 –44 years of age.

Figure 39 shows that the number of HIV infection cases among all women delivering live births has been stable during the past seven years, averaging about 100 per year. The rate, though, is nearly 9 times higher among African American women compared to white women.

Figure 39a: Infants Born to HIV+Mothers, Case Rate* by District, Births 2001 - 2002



Rate per 100,000 Women 13-44 yrs./district population

Figure 39a shows the rate of HIV infection among women delivering live births per total population of women of child-bearing age by district. Pee Dee has the highest rate (41.3), followed by Low Country (40.6). These areas are also reflected in the graphs below showing counties with higher rates of persons living with HIV/AIDS.

Figure 40 shows the counties with highest prevalence of persons living with HIV/AIDS due to heterosexual transmission. These are the more urban counties of Florence, Greenville/Spartanburg, Richland, Lexington, Sumter, Orangeburg, Horry and Charleston as well as Darlington county. Figure 41 shows the case rate for 2002-2004 among women, an indicator for more recent heterosexual risk. Richland, Sumter, Williamsburg, as well as rural Clarendon, and Allendale counties had the highest case in the state.

Figure 40: SC HIV Prevalence by Exposure Category, 2004 Reported Cases, by County Heterosexual Contact

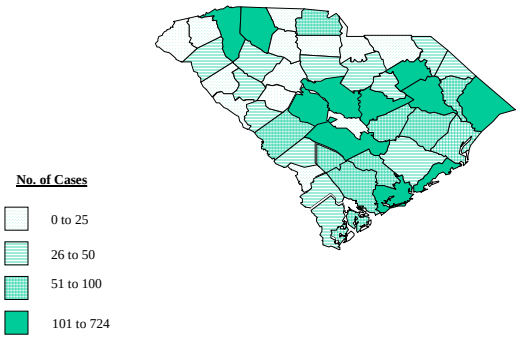
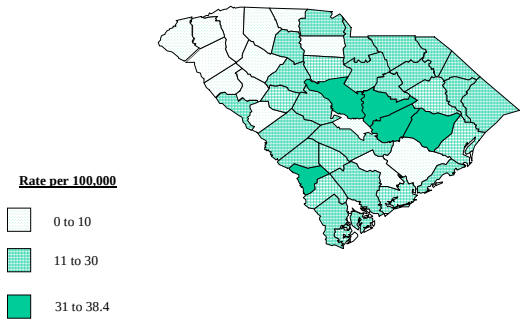


Figure 41: SC HIV Incidence Rates (per 100,000 population) 2002-2004 Average of Cases Females



Conclusions

These data indicate that prevention efforts targeted to high risk heterosexuals need to be tailored to African American, particularly young women under age 25, who account for about two-thirds of both living cases and more recently diagnosed persons in this age group. Efforts also need to

target African American men and women 25 – 44 years, who account for over three-fourths of living and more recently diagnosed cases (all ages). Prevention efforts targeting African American men and women should also be tailored to reach those 45 years and older.

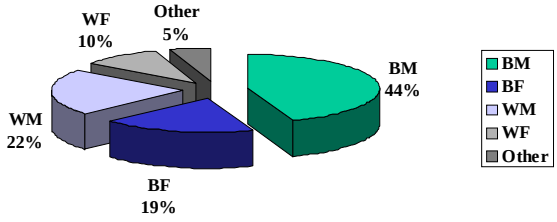
Injecting Drug Users

Estimates of Injecting Drug Use Behavior in South Carolina
According to 1999-2000 estimates of heroine use provided by the SC Department of Alcohol and Other Drug Abuse Services (DAODAS), there are 8,000 persons in South Carolina who are injecting drug users in need of treatment services.

Characteristics of Injecting Drug Users

Note: persons who are categorized as both men who have sex with men and injecting drug users are included in this population description.

Figure 42: Proportion of Injecting Drug Users Diagnosed with HIV/AIDS 2003-2004 by Race/Sex N=110



Injecting drug users (IDU's) account for 20% of the persons presumed living with HIV/AIDS in 2004 and 9% of persons more recently diagnosed with HIV/AIDS during 2003-2004. The number of IDU cases diagnosed each year decreased 50% from 2000 to 2004 (See Figure 30).

Figure 42 shows that 44% of recently diagnosed injecting drug use cases are African American men; African American women account for 19% of cases. White men account for 22% of recent diagnoses and the least proportion is among white women (10%).

Men are overwhelmingly impacted by HIV transmitted by injecting drug use, averaging 3 cases to every one case reported among women each year. Men show a decrease in number of diagnosed IDU cases since 1998. For this same period, the number of diagnosed IDU cases women was fairly stable. The increase in 1998 cases for men is likely due to targeted screening in corrections facilities, identifying more new cases that year. (Figure 43)

Figure 43: Number of HIV/AIDS Cases Due to Injecting Drug Use by Sex and Year of Diagnosis, 1988-2004

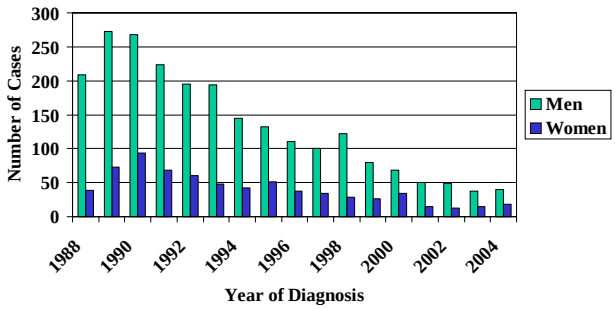


Figure 44: Percent of Injecting Drug Users Diagnosed with HIV/AIDS 2003-2004 by Age Group N=111

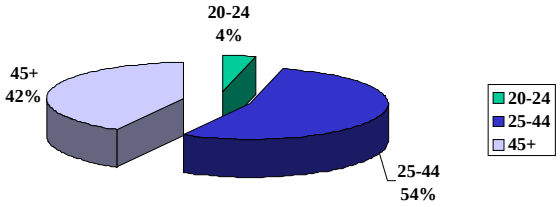


Figure 44 shows that 54% of recently diagnosed IDU cases are 25 – 44 years of age; 42% are 45 years and older. Only 4% of persons diagnosed during 2003-2004 were under 25 years.

Similarly, persons living with HIV/AIDS due to injecting drug use are largely 25 years of age and older (92%). African Americans account for the greatest proportion of cases in each age group, with African American men accounting for over 57% of those older than 25 years. (Figure 45)

Figure 45: Percent of IDU Persons Presumed Living with HIV/AIDS by Race/Sex and Age Group, 2004 N=2027

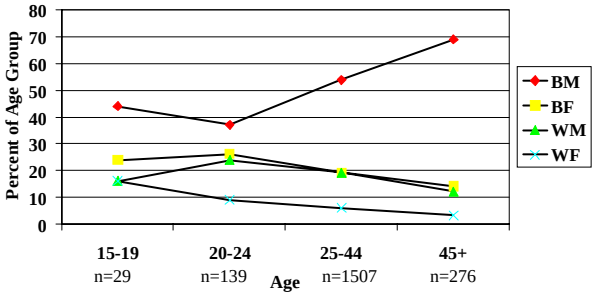


Figure 46: HIV Prevalence by Exposure Category, 2004 Reported Cases, by County IDU

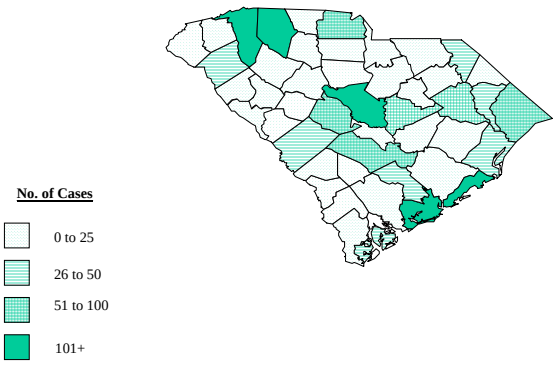


Figure 46 indicates the counties with the highest number of persons living with HIV with injecting drug use risk (Richland, Greenville/Spartanburg, and Charleston). As with other risks, the more urban counties have the greatest numbers.

Conclusions

Prevention efforts targeting injecting drug users need to be tailored to men, primarily African American men who comprise a majority of recently diagnosed cases, followed by white men and African American women. Efforts should target persons older than 25 years and those who are predominately in more urban counties including Lexington, York, Florence, Horry, Orangeburg and Sumter.

Other Populations

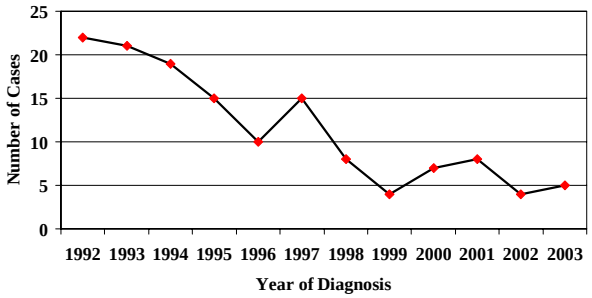
Other populations at varying risk for HIV are described below and include infants and children, incarcerated persons, persons with sexually transmitted diseases, and pregnant teen-age women.

Infants and Children: (Children under 13 years of age)

The majority of infants and children are infected with HIV through exposure to their mother during pregnancy. Through December 2004, there were 204 HIV infection cases diagnosed among children less than 13 years of age, of which 120 had AIDS. This represents 1.0 percent of the total reported AIDS and HIV infection cases. The majority of the children with HIV are black.

There has been significant progress during the past five years in reducing the number of infants with perinatal acquired HIV infection. Figure 47 shows the decline in the number of infants diagnosed from 16 cases in 1997 to 5 cases in 2003.

Figure 47: Number of Children <13 Years Old Diagnosed with HIV/AIDS in South Carolina, 1992-2003



Source: SCDHEC, HARS

Incarcerated Persons

Incarcerated persons are another special population of concern; the Centers for Disease Control estimates that 25% of all U.S. HIV infected people have passed through a correctional facility before. Recent interviews with HIV infected persons in South Carolina indicated that more than one-fourth (26.3%) reported having been incarcerated. This places a very large percentage of our population at risk. HIV infected inmates who are released from prisons need continued preventive and care efforts for themselves and partners when released into the community.

The SC Department of Corrections (DOC) currently house all HIV infected inmates in two facilities, one for men and one for women. This enables the DOC to better coordinate care and support services to infected inmates. All new inmates receive HIV screening and if positive are placed in the designated facility. Currently 500 men and 37 women inmates are HIV infected. During the five-year period 1998-2003, there were 624 persons diagnosed with HIV/AIDS by state prison facilities. Note: due to mandatory screening in the prison initiated in 1998, there were an increased number of cases diagnosed that year (251); during 1999 – 2003, the average number of cases diagnosed is much less, about 75 per year. African American men accounted for 79% of the 624 cases; white men were 9% of the total, African American women were 10%, and white female were 2%. Of the 358 persons who reported risks, 37% reported heterosexual risk; 31% reported injecting drug use (and injecting drug use/male to male sex); and 31% reported male to male sex.

During the past four years, DOC staff, state Ryan White Title II and Midlands consortia staff have met to plan and develop a system of discharge to ensure HIV infected inmates are efficiently linked to the consortia and care services within 30 days of release. This is to ensure a

continuity of care and maintenance of therapies currently taken while in correctional facilities. The DOC provides inmates a 30-day supply of medications upon release.

Persons with Sexually Transmitted Diseases (STDs)

STDs are primary risk factors for HIV infection and a marker of high risk, unprotected sexual behavior. Many STDs cause lesions or other skin conditions that facilitate HIV infection. Trends in STD infection among different populations (e.g. adolescents, women, men who have sex with men) may reflect changing patterns in HIV infection that have not yet become evident in the HIV/AIDS caseload of a particular area.

Chlamydia

In 2004, there were 20,116 cases of chlamydia diagnosed in South Carolina. Figure 48 shows the increase of chlamydia as a result of initiating routine screening for all young women attending family planning and STD clinics in health departments statewide. Among those cases with reported race/gender, over two-thirds were African American women (67%); 20% were white women in 2004. Hispanic men and women accounted for 2% of cases in 2004.

Figure 48: South Carolina Reported Chlamydia Cases by Year of Diagnosis, 1992 - 2004

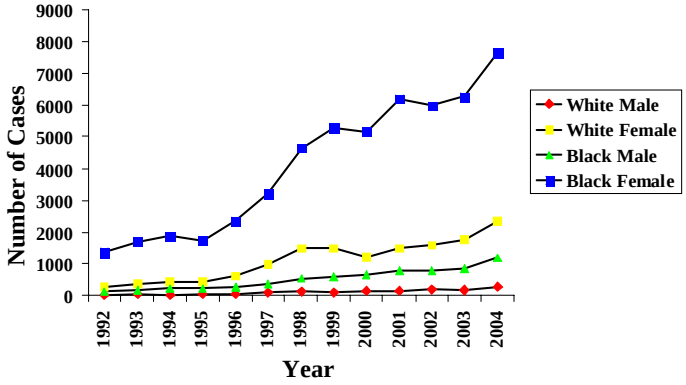


Figure 49: Proportion of 2004 Reported Chlamydia Cases by Year of Diagnosis by Age Group

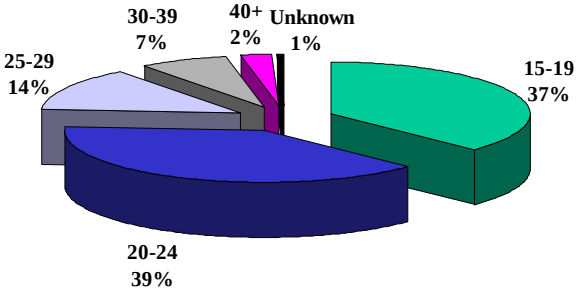


Figure 49 shows that in 2004 young adults 15-19 and 20-24 have the highest proportion of chlamydia (37% and 39%, respectively), followed by those 25-29 years of age. Counties with highest chlamydia rates per 100,000 population in 2004 were Hampton (1,853.0), Bamberg (1,132.2), and Allendale (1,019.9).

Gonorrhea

In 2004, 9,588 gonorrhea cases were diagnosed. African American men and women account for 84% of reported cases with known race/gender in 2004. Figure 50 shows trends among race/gender by year.

Figure 50: South Carolina Reported Gonorrhea Cases by Year of Diagnosis, 1992 - 2004

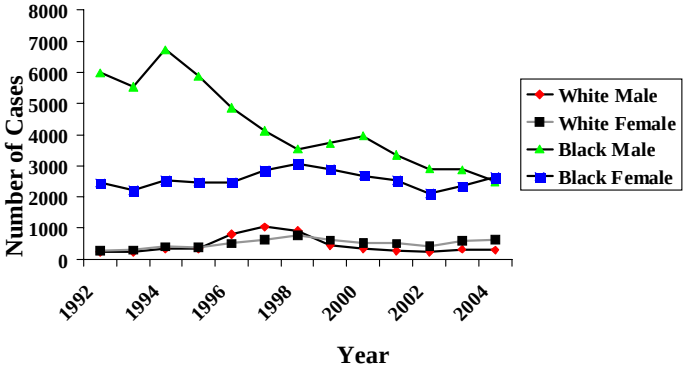
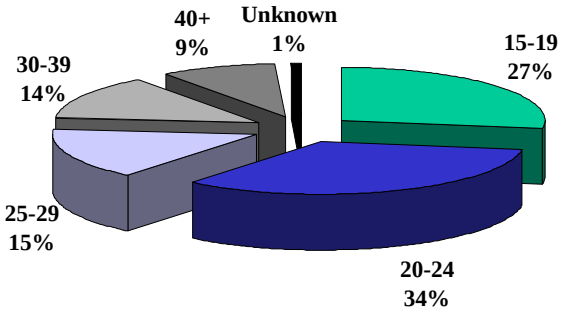


Figure 51 : Proportion of 2004 Reported Gonorrhea Cases by Year of Diagnosis by Age Group



As with chlamydia, gonorrhea cases most affect young adults 15-24 years of age (61% of total) (Figure 51). Counties with highest rates per 100,000 of gonorrhea in 2004 were Hampton (1,548.1); Bamberg (489.6); and Allendale (484.0).

Infectious Syphilis

In 2004, 108 cases of infectious syphilis were diagnosed. As Figure 52 shows, significant decreases have occurred during the past ten years for all infectious syphilis cases. As with other STDs, African Americans are most impacted, accounting for 66% of total cases. Unlike other STDs, syphilis most impacts older adults, 30 years and older (66% of total) (Figure 53). Counties with highest infectious syphilis rates per 100,000 population in 2004 were Anderson (15.9), Abbeville (15.1), and Sumter (6.4).

Figure 52: South Carolina Reported Infectious Syphilis Cases by Year of Diagnosis, 1992-2004

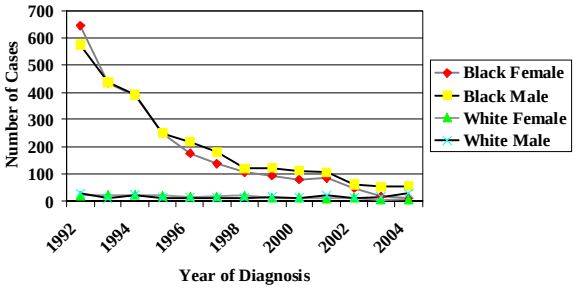
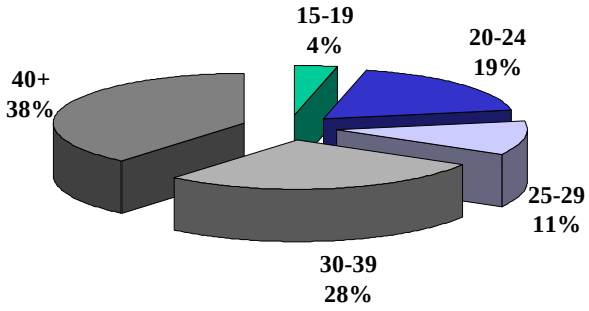


Figure 53: Proportion of 2004 Reported Infectious Syphilis Cases by Year of Diagnosis by Age Group

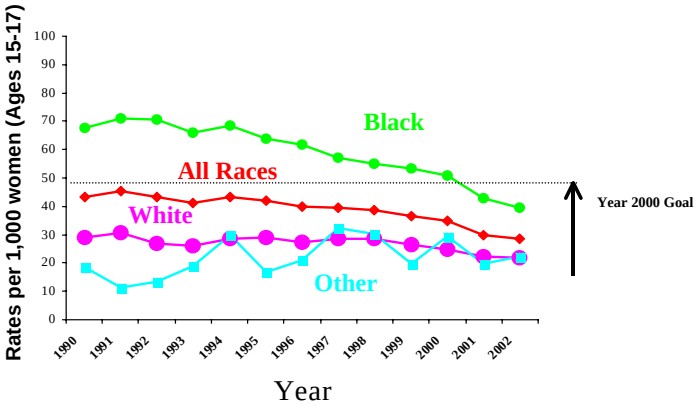


Teenage Pregnancy

Pregnancy, birth and abortion rates, like STD rates, are indications of the extent of unprotected sexual activity in a population.

African American girls (including less than 1% "other") between the ages of 10 and 14 have continued to have higher rates of live births than their white counter parts. However, their rates have decreased from

Figure 54: South Carolina Teenage Live Births Rates, Ages 15 - 17

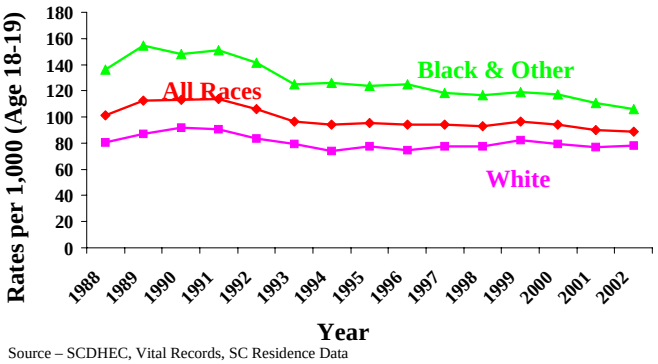


Source – SCDHEC, Vital Records, SC Residence Data

4.2 in 1988 to 2.4 per 100,000 in 2003, respectively.
Teenage pregnancies among 15-17 year old South Carolinians have decreased from a rate of 43.2 per 1,000 live births in 1990 to 28.7 in 2002; a 34% decline (Figure 54). This success is also seen when viewing teen pregnancy by racial/ethnic subgroups. The rate for White 15-17 year old teens was 29.1 in 1990 and 22.0 in 2002, representing a 24% decline. The rate for Black and others was 86.0 in 1987 and 80.4 in 2000, representing a 7% decline. The rate for Blacks was 61.9 in 1996 and 39.5 in 2002, representing a 36% decline. The rate for Others is the only exception to a consistent declining trend where the rate was 21.2 in 1996 and climbed to 30.4 in 1998 and down again to 22.2 in 2002, representing a 5% increase in the rate over the 1996 to 2002 period. This fluctuation may be due to small numbers and the trend for this subgroup requires further observation.

Figure 55 shows the teen pregnancy rates for 18 and 19 year olds. As with the other two age groups, African American and other teenage girls continue to have higher live birth rates over the 15-year period than all races. But also as seen in the other age groups their rates have decreased from 136.2 to 105.9, 1988 and 2002, respectively.

Figure 55: South Carolina Teenage Live Births Rates Ages 18-19



Source – SCDHEC, Vital Records, SC Residence Data

Persons Receiving HIV Counseling and Testing At County Health Departments (C&T Sites)

Data from local HIV counseling and testing sites (county health departments) generally reflect similar trends as HIV/AIDS surveillance data in terms of who is most likely to be HIV infected, risk category, and county of residence. As stated in the Introduction, the data reflects only those persons tested voluntarily in local health departments. HIV infected persons diagnosed through counseling and testing sites account for about one-third of the newly diagnosed persons in South Carolina annually. This data reflects number of individuals tested, not the number of tests. In 2004, African Americans comprised 62% of the total persons tested, but 79% of the total positive. Men accounted for 41% of persons tested but 67% of total positive. Persons 30-39 and 40-49 years of age had the highest positivity rate and comprised 64% of the total positive persons.

Men who have sex with men had the highest positivity rate (13.6%), followed by all heterosexuals at risk (10.8%), and heterosexual injecting drug users (12.9%). Heterosexual partners of persons with HIV had the highest positivity rate (20.3%).

Health districts that accounted for the greatest proportion of persons tested who were positive include those with the same urban counties of highest prevalence: Palmetto District (includes

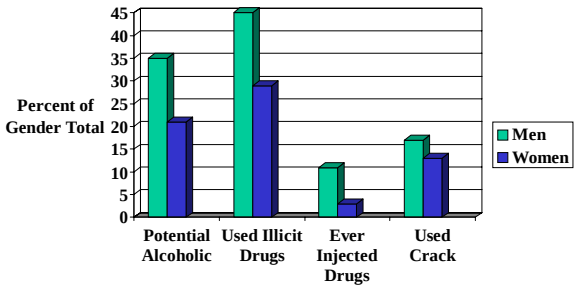
Richland County)- 20% of total positives tested; Trident (Charleston County)- 13% of total positives; Edisto (Orangeburg County) – 11% of total positives; Appalachia II (Spartanburg County), Waccamaw (Horry County), and Low Country (Beaufort County) – each 8% of total positives.

Other Behavioral/Risk Data

Supplemental HIV/AIDS Surveillance

DHEC participates in an in-depth survey of persons with HIV/AIDS known as the Supplement to HIV/AIDS Surveillance (SHAS) sponsored by the U.S. Centers for Disease Control. Persons diagnosed with HIV/AIDS living in Richland, Charleston, Orangeburg, Bamberg, Calhoun counties participate in the survey. Eighty-four percent of participants are African American; 14% are white. During July 2002 to March 2004, there were 376 persons interviewed. Regarding sexual activity, 28% reported same sex activity (MSM); 72% reported heterosexual activity. About two-thirds (73%) of persons interviewed were asymptomatic HIV (not AIDS), representing more recent infection.

Figure 56: Substance Use Risks by Sex, 7/2002-3/2004 SHAS Participants N=376

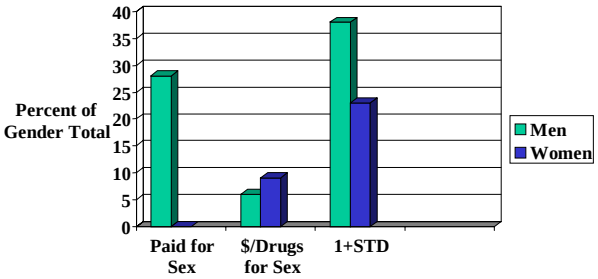


Total Men=249 Total Women=127

Substance use during past 5 years or present was reported by one-third of persons with HIV interviewed: 30% reported potential alcoholic, 40% used illicit drugs during past five years. Nine percent reported ever injecting drugs and 16% had used crack. Figure 56 shows the proportion of men and women interviewed who reported substance use risk. More men than women reported each substance use related risk with men reporting injecting drug use more than 3 times as much than women.

Sexual risks reported by persons interviewed from July 2002 to March 2004 indicate that 28% of men paid some one for sex; 9% of women received either money or drugs for sex (Figure 57). Thirty-eight percent of men and 23% of women reported having at least one sexually transmitted disease (STD) during the past ten years.

Figure 57: Sexual Risk Behaviors, 7/2002-3/2004 SHAS Participants N=376



Behavioral Risk Factor Surveillance System (BRFSS)

Behavior Risk Factor Surveillance System is the world's largest random telephone survey of non-institutionalized population aged 18 or older that is used to track health risks in the United States. In 1981, the Centers for Disease Control

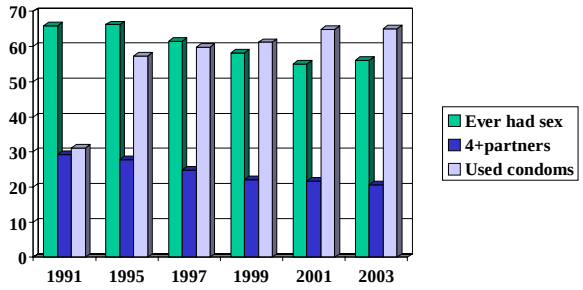
and Prevention (CDC), in collaboration with selected states, initiated a telephone based behavioral risk factor surveillance system to monitor health risk behaviors. South Carolina began administering BRFSS since 1984. Several core questions address knowledge, attitudes, beliefs, and behaviors regarding sexually transmitted diseases, particularly AIDS.

Results of the 2003 survey suggest most respondents have a fair knowledge of transmission and treatments of HIV/AIDS. Seventy-five percent of respondents said they believed treatments are available to HIV+ women to reduce the chance of transmission to the baby, and 96% believed medical treatments are available to help HIV+ persons live longer. Regarding attitudes about individuals' HIV status, 96% of respondents indicated it was very important for people to get tested, however, only 51% of respondents indicated ever being tested for HIV themselves with 60% of those having been tested in the past 3 years. Most respondents who had been tested revealed the main reason for the test was part of a check-up (33.9%), pregnancy (13.3%), or required (14.8%). Twenty-one percent said testing was their own choice. When asked if in the past 12 months if a doctor, nurse, or health professional discussed condom use for preventing STDs, a majority (85.6%) said this had not occurred.

Youth Risk Behavior Survey

The Youth Risk Behavior Survey is administered to students in public high school in South Carolina. Figure 58 shows that over time there has been slight decreases in the proportion of students who have been sexually active, had four or more lifetime partners, and increases in those reporting condom use at last sexual intercourse.

Figure 58: Proportion of YRBS Students Indicating Sexual Risks, 1991 - 2003



Substance Use

A 1999-2000 household telephone survey of 10,324 adults ≥18 yrs was conducted by the SC Department of Alcohol and Other Drug Use Services (DAODAS) to assess substance use practices. Results indicated that 37% of persons used alcohol during past 30 days, 3% used marijuana, and less than 0.5% used cocaine and hallucinogens during past month. General patterns of substance use by persons in the state indicate that more men than women use drugs/alcohol; higher use levels are generally among younger respondents (18 – 44 years of age).

Summary/Recommendations

A review of this epidemiological profile indicates the following primary target populations and recommendations for prevention efforts:

Men Who Have Sex With Men

These data indicate that prevention efforts targeted to men who have sex with men need to be tailored to both African American and white men. African American men account for the majority of both living cases (55%) and newly diagnosed HIV/AIDS cases (64%) who report

MSM risk. Increased efforts in particular are needed to reach younger African American MSM <25 years of age; for white men, targeted efforts are needed for those >25 years. Interventions also need to be particularly available for persons living in the more urban areas of the state.

Heterosexuals

These data indicate that prevention efforts targeted to high risk heterosexuals need to be tailored to African American women, particularly young women under age 25, who account for nearly two-thirds of both living heterosexual cases and more recently diagnosed persons in this age group. Efforts also need to target African American men and women 25 – 44 years, who account for over three-fourths of living and more recently diagnosed cases (all ages). Prevention efforts targeting African American men and women should also be tailored to reach those 45 years and older.

Injecting Drug Users

Prevention efforts targeting injecting drug users need to be tailored to men, primarily African American men who comprise over half of recently diagnosed IDU cases, followed by white men and African American women. Efforts should target persons older than 25 years and those who are predominately in more urban counties including Lexington, York, Florence, Horry, Orangeburg and Sumter.

Due to high proportion of HIV infection among incarcerated persons and high rates of sexually transmitted diseases, efforts to reach these priority populations should include prison facilities and STD clinics and community screening sites.

RWCA Question #1: What are the patterns of service utilization of HIV-infected persons?

In 1990, Congress enacted the Ryan White CARE Act to provide funding for states, territories and EMAs to offer medical care and support services for persons living with HIV disease who lack health insurance and financial resources for their care. Congress reauthorized the Ryan White CARE Act in 1996 and 2000 to support Titles I through IV, Special Projects of National Significance (SPNS), the HIV/AIDS Education Training Centers and the Dental Reimbusement Program, all of which are part of the CARE Act.

Title II funding is used to assist States and Territories in developing and/or enhancing access to a comprehensive continuum of high quality, community-based care for low-income individuals and families living with HIV.

Figure 59: Demographic Characteristics of CARE Act Title II Clients Compared with Characteristics of Persons Living with HIV/AIDS, South Carolina, 2004

	CARE Act Clients, N=7815, %	Persons Living with HIV/AIDS, N=13,748, %
Race/Ethnicity		
White, not-Hispanic	22%	25%
Black, not-Hispanic	74%	73%
Hispanic	2%	2%
Other	1%	<1%
Sex		
Male	62%	69%
Female	36%	31%
Transgender	<1%	---
Age Group		
<13	<1%	1%
13-24	4%	16%
25-44	59%	67%
45+	35%	16%

During 2004, 7,815 clients received services through the Ryan White Title II funds. Of these, 1,777 were new clients. Figure 59 presents the distribution of Title II clients by race/ethnicity, sex and age as well as for those persons living with HIV/AIDS in South Carolina through December 2004. Clients served through Title II are representative of the population affected with HIV/AIDS in all categories.

HRSA has directed that States should allocate funds for essential core services: 1) Primary Medical Care consistent with Public Health Service (PHS) Treatment Guidelines; 2) HIV Related Medications; 3) Mental Health Treatment; 4) Substance Abuse Treatment; 5) Oral Health; and 6) Case Management.

Figure 60 shows a break down of Ryan White II clients who received five of the six core services through funding and the average number of visits per clients. Utilization of HIV related medications is described in the ADAP section. Among the 7,815 clients who received services, the majority of clients obtained case management services (n=6,031) followed by medical care

(n=3,524), dental care (n=479), substance abuse services (n=206), and mental health services (n=191).

Of those services utilized more by clients (visits/clients), case management services were among the highest (15.3 visits per clients), followed by substance abuse services (8.0 visits per client) and medical care (6.3 visits per client). Clients receiving dental care and mental health services averaged about two visits in 2004.

Figure 60: South Carolina Ryan White Title II Service Utilization by Service Type, 2004

	No. of clients receiving service	Avg. no. of visits per client
Medical Care	3,524	6.3
Medication (ADAP)	2,791	N/A
Oral/Dental Care	479	2.0
Mental Health	191	1.7
Substance Abuse	206	8.0
Case Management	6,031	15.3

Additional services obtained by clients in 2004 included treatment adherence, counseling, buddy/companion services, client advocacy, food bank/home delivered meals, health education/risk reduction, referral for health care and supportive services, psychological support services, housing assistance and transportation services.

AIDS Drug Assistance Program (ADAP)

The South Carolina AIDS Drug Assistance program (SC ADAP) was established under the Ryan White CARE Act to provide drugs to treat HIV disease and/or to prevent the serious deterioration of health arising from HIV disease in eligible individuals, including measures for the prevention and treatment of opportunistic infections and document the progress made in making the drugs available. The SC ADAP is operated through a centralized pharmacy and an insurance assistance program located at the Department of Health and Environmental Control. Currently 57 drugs are on the approved formulary. During calendar year 2004, ADAP served 2,791 clients, 815 of whom were new clients. The SC ADAP has an advisory body of infectious disease (ID) physicians and program staff that meets annually to review the SC ADAP formulary and make recommendations for program improvements.

In the past, once an antiretroviral medication received FDA approval, it was automatically added to the SC ADAP formulary. With the new development of extremely expensive therapies, such drugs are added as appropriate after consultation with the SC ADAP Medical Advisory

Committee. Fuzeon, pegylated interferon and ribavirin currently require prior reauthorization for approval. No restrictions or caps on the number of other Antiretroviral medications per client exist.

Eligibility in ADAP includes verified HIV positive status, South Carolina residency, and limited income. The financial requirement is measured according to the Federal Poverty Guidelines. Eligibility remains at 300% of the Federal Poverty Guidelines, and the sliding fee scale includes up to 550% of poverty level. Expenditures are carefully monitored and projections are reviewed monthly.

Figure 61 lists the characteristics of clients enrolled in the ADAP program during 2004. Clients served through ADAP have a similar distribution to that of persons living with HIV/AIDS in South Carolina. The majority of the clients are non-Hispanic African Americans/Black (69%), male (70%), and in the 25-44 year age group.

In South Carolina, the amount expended by ADAP for CY2002 amounted to approximately 1.1 million with 2,262 clients served; almost $12 million in CY2003 was expended on 2,452 clients; and $12.9 million in CY2004. Figure 61a illustrates monthly expenditures for this three-year period.

Figure 61: 2004 ADAP Patient Profile Compared to Persons Living with HIV/AIDS

Profile	SC HIV/AIDS Prevalence, 12/31/04: 13,748 Persons	Central Pharmacy Total Served: 2,209	Insurance Program Total Served: 582
Male	69%	70%	70%
Female	31%	30%	30%
African American	73%	72%	70%
White	25%	23%	27%
Hispanic/Latino	2%	3%	1%
Proportion Below Federal Poverty Guidelines (FPG)	NA	59% ≤ 100% FPG	23% ≤ 100% FPG
	NA	33% ≤ 200% FPG	28% ≤ 200% FPG
	NA	7% ≤ 300% FPG	31% ≤ 300% FPG
	NA	1% >300% FPG	8% >300% FPG

South Carolina AIDS Drug Assistance Program
SC ADAP Monthly Expenditures
January 2002-December 2004

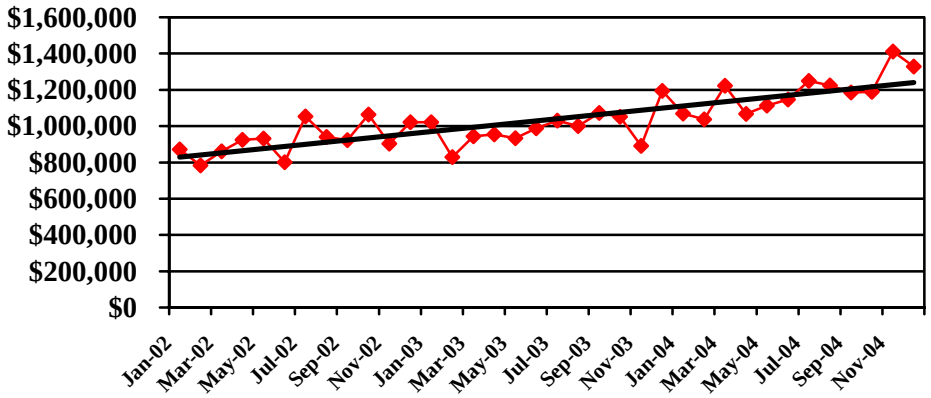


Figure 61a: SC ADAP Monthly Expenditures

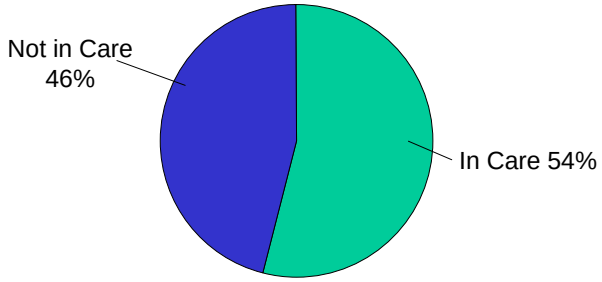
RWCA Question #2: What are the number and characteristics of persons who know they are HIV+ but who are not receiving HIV primary medical care?

To analyze the number of persons living with HIV/AIDS in South Carolina not "in care," HARS (HIV/AIDS Reporting System) data was used to review all persons diagnosed through July 2004. HARS in South Carolina is a laboratory based reporting system with all CD4 and viral load tests being reportable as of January 1, 2004. Persons who were deceased as of July 1, 2004 were excluded from the analysis. Only current SC residents were included. A person was reported as being "in care" if they had at least one CD4 or viral load test report from July 1, 2004 through June 30, 2005. Persons with no CD4 or viral report in this time frame were defined as "not in care".

South Carolina conducted the Interstate Duplication Evaluation Project (IDEP) in 2002 assuring that HARS eliminated duplicate cases across states.

Figure 62 shows that of the 12,821 patients diagnosed through July 1, 2004, 46% (5,894) patients did not receive a CD4 or viral load test report within the specified time period,

Figure 62: SC HIV/AIDS Cases Estimated Not in Care vs. In Care Diagnosed through 7/2004 (N=12,821)



therefore are reported as "not in care". Fifty-four percent are defined as "in care". Of the 5,894 clients not in care, 55% are living with HIV-only and 45% are living with AIDS (Figure 63).

Figure 63: SC HIV/AIDS Cases Estimated NOT in Care Diagnosed through 7/2004, HIV-only vs. AIDS (N=5,894)

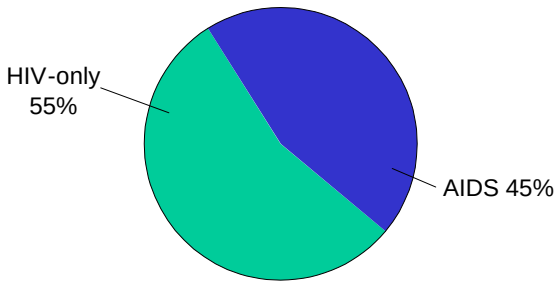
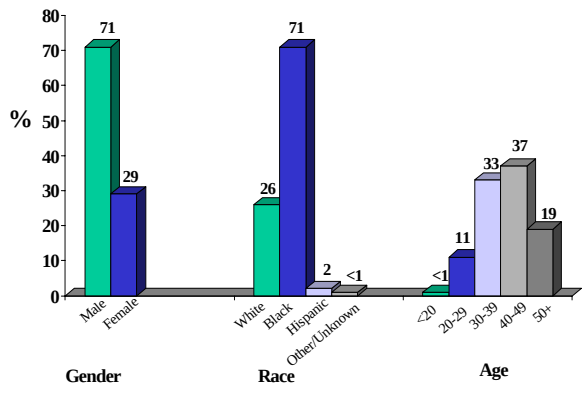


Figure 64 demonstrates a comparison of persons not in care by select demographics. By gender, the number of men not in care (71%) is more than double of the number of women not in care (29%). Seventy-one percent of those not in care are African Americans. In addition, a comparison by age groups shows that most persons living with HIV/AIDS and not receiving care are between the ages of 30-49 (70%),

Figure 64: SC HIV/AIDS Cases Diagnosed through 7/2004, Comparison within Select Demographics Estimated Percentage Not In Care



followed by those who are 50+ (19%) and 20-29 (11%).

An analysis by mode of exposure of persons living with HIV/AIDS indicates most persons not in care are MSM (39%) and heterosexuals (36%) followed by IDUs (23%) (Figure 65) Figure 66 goes further to compare those in care versus those not in care within each risk category. Among all MSMs living with HIV/AIDS, more persons are in care (56%) than not in care (44%). Focusing on those persons whose mode of exposure was injecting drug use, more than half are not in care (53%) rather than in care (48%). Among heterosexuals with HIV/AIDS, 59% are in care versus 41% not in care.

Figure 67: SC HIV/AIDS Cases Estimated NOT in Care Diagnosed through 7/2004, by Location (N=5,894)

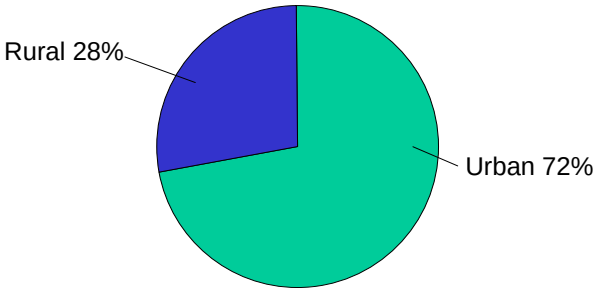
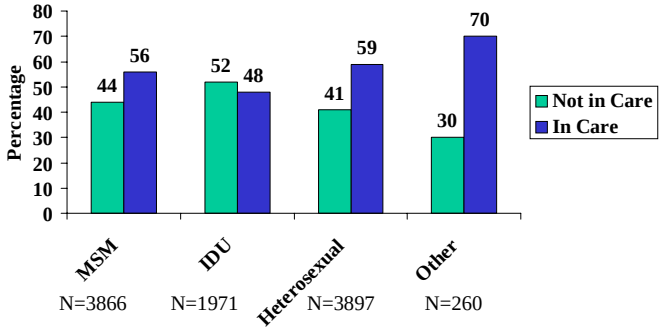
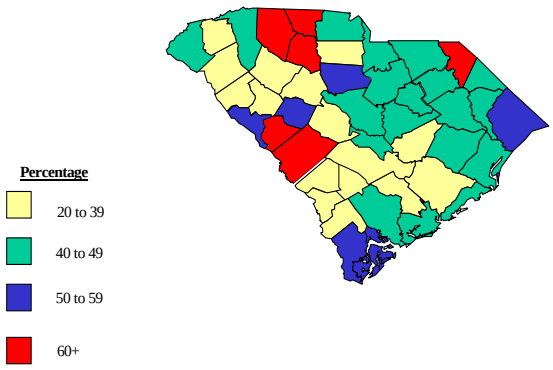


Figure 66: SC HIV/AIDS Cases Diagnosed through 7/2004, Comparison within Mode of Exposure In Care vs. Not in Care



The location of a person's residence may have an impact of whether or not they are in care. There are more persons not in care from urban areas (72%) versus rural areas (28%). Figure 67 and 68.

Figure 68: SC HIV/AIDS Cases NOT in Care Diagnosed through 7/2004, by County



II. PLWHA in Care

This section focuses on the needs of PLWHA who are already receiving Ryan White CARE Act funded services (i.e., PLWHA in care) and is organized according to the six core service areas. Each service area includes a three-year goal, barriers and gaps in meeting the needs of PLWHA with regard to that service, and proposed strategies for addressing those needs. The section concludes with a description of barriers and gaps common across the six service areas.

1. Primary Medical Care

Goal: By January 2009, improve the quality and accessibility of medical care consistent with Pubic Health Service treatment guidelines for PLWHA who are in care.

Barriers and Gaps

- Shortage of trained providers, especially in rural areas
- No public transportation in rural areas and limited access in urban areas make it difficult to get to appointments
- High no-show rates in clinic due to clients' complex lifestyles and competing demands, distrust of doctors and case managers, lack of cultural sensitivity among front desk and clinic staff, and long wait times for appointments and in waiting room
- Large number of clients overburdens agencies with level Ryan White funding
- Low medical literacy among clients
- Complex medical needs/multiple diagnoses of clients

Strategies

- Provide day care and other support services and linkages for patients on site.
- Establish more flexible clinic hours to increase accessibility of care.
- Provide ongoing cultural competency training for all providers and staff.
- Utilize peer educators to increase the cultural sensitivity of the clinic environment.
- Involve nurse educators and peer educators in improving medical literacy among clients.
- Provide educational materials at appropriate comprehension levels.

HIV-Related Medications

Goal: By January 2009, increase the accessibility of effective HIV-related medications for PLWHA who are in care.

Barriers and Gaps

- Lack of client knowledge about the importance of medication adherence
- Multiple diagnoses in clients (e.g., substance abuse and mental illness) complicate medications adherence and leads to drug resistance

- Stigma and concerns about disclosure stemming from patient's need to store some medications in their refrigerator or other "public" areas
- Lack of stable housing such that clients do not have a reliable address to which medications can be mailed and do not have a place to store medications
- Limited patient assistance programs for non-documented residents
- Clients in county jails often do not receive prescribed medications
- Complex paperwork (recertifications) make it difficult to maintain ADAP eligibility
- Lack of provider knowledge about ADAP
- Medications for side effects are not included in ADAP formulary
- Insurance policies that do not fully reimburse when clients pay for medications up front
- Clients that do not bring in their insurance reimbursement checks when consortia pay for medications up front
- Limited availability of non-HIV medications

Strategies

- Improve the effectiveness of substance abuse and mental health services to help mitigate issues that affect medications adherence.
- Use peer counselors and nurse educators to increase awareness of medications issues and improve medications adherence.
- Establish clear consequences and incentives to improve medication adherence.
- Increase funding for medications assistance through grant writing, fundraising, and lobbying.
- Join efforts to pass universal health care legislation.

Mental Health Treatment

Goal: By January 2009, enhance mental health services for PLWHA who are in care.

Barriers and Gaps

- Stigma of mental illness makes clients less receptive to accessing mental health treatment
- Stigma of HIV makes mental health providers less willing to treat PLWHA
- Difficulty developing long-term referral partnerships with mental health authorities at the state and local level
- Inability / refusal of mental health support systems to coordinate and maintain a continuum of care for PLWHA that leads to long term maintenance of diagnosed mental health conditions
- Long wait times for mental health services due to inefficiencies within the mental health service system
- Lack of transportation to mental health providers, especially in rural areas
- Limited number of mental health providers to address needs of PLWHA, especially in rural areas
- Insufficient funding to support mental health services for PLWHA

Strategies

- Conduct consortia level needs assessment to determine the capacity of individual organizations to provide high quality, culturally competent mental health services.
- Develop policy mandates to include mental health services within the Ryan White consortium system and create a process to fund those mandates.
- Incorporate a standardized mental health assessment within the Ryan White title structure to enhance identification and referral of clients across organizations and systems.
- Develop teams of mental health providers wiling to offer pro bono mental health services.
- Enhance collaborations between state and local mental health authorities, CBOs, and ASOs.

Substance Abuse Treatment

Goal: By January 2009, increase the quality, accessibility, and utilization of substance abuse treatment services for PLWHA who are in care.

Barriers and Gaps

- Insufficient number of qualified providers, substance abuse treatment facilities, and treatment beds to meet need for services
- Lack of transportation to substance abuse treatment services, especially in rural areas
- Low priority of substance abuse among funders leading to inadequate resources for treatment
- Biases and stigmatizing attitudes of agency staff toward addicted persons
- Hesitancy of families to get involved in helping addicted persons

Strategies

- Train all providers and support staff along the continuum of services (e.g., physicians, nurses, case mangers, receptionists) to understand addiction and to overcome any personal stigma and biases toward addicted persons.
- Provide all agency staff and providers with ongoing peer support and feedback to help address any personal stigma and biases toward addicted persons.
- Conduct a public education campaign about addiction through multiple media channels that is collaboratively supported by agencies with the goal of increasing community understanding of addiction and reducing stigma and biases toward addicted persons.
- Explore new strategic alliances and collaborations among providers that serve PLWHA who are addicted by identifying potential partnerships and co-authoring grants with agencies, businesses, churches, and teaching hospitals.

Oral Health

Goal: By January 2009, increase the accessibility of oral health services and the participation of providers and clients in maintaining the oral health of PLWHA who are in care.

Barriers and Gaps

- Insufficient attention to oral health among case managers and other providers, e.g., oral health not included in initial assessments of client needs
- Added time and cost involved in assessing clients' oral health needs
- Fear of HIV among providers and the possible loss of business due to the stigma of being known as the "HIV dentist"
- Attitude of providers that it is not worth treating active crystal methamphetamine users because of this drug's adverse effects on oral health
- Lack of client understanding of the importance of good oral health
- Apprehension among clients about going to the dentist
- Limited transportation to dentists, especially in rural areas
- Lack of fundraising and funding for oral health services

Strategies

- Identify more oral health providers by educating providers about the oral health needs of PLWHA, negotiating agreements for services and payments, and managing existing funds for oral health care more efficiently.
- Strengthen and expand collaboration across multiple agencies to share existing oral health care resources and to secure additional funds through collaborative grants.
- Emphasize clients' ownership and investment in their own oral health behaviors by establishing co-pay for oral health services were appropriate.
- Include oral health as part of an initial comprehensive client assessment conducted by medical care providers and case mangers.
- Establish oral health care plans for clients that include assessment of oral health needs, identification of steps for problem resolution, and establishment of plans for oral health preventive care and maintenance.
- Educate medical providers and case managers about issues related to clients' fear of dentists and about providers' concerns about HIV stigma and providing care to crystal methamphetamine users.
- Educate clients about the importance of oral health and to mitigate their fear of dentists.

Case Management

Goal: By January 2009, increase the quality and accessibility of case management services for PLWHA who are in care.

Barriers and Gaps

- Complex needs of clients with multiple diagnosis (e.g., mental health and substance abuse) make it difficult to help clients effectively manage their needs
- Lack of client and provider understanding of comprehensive case management and the role of case managers
- Challenge of establishing clear boundaries between clients and case managers so as to empower clients without enabling
- Reactive versus proactive approach of providers and clients to addressing needs
- Large caseloads that exceed capacity of case managers
- Staff turnover that disrupts rapport with clients

Strategies

- Establish effective mechanisms for case managers to collaborate with substance abuse and mental health providers.
- Conduct a social marketing campaign for clients and providers with the goal of increasing their understanding of comprehensive case management and the role of case managers.
- Develop HIV case manager certification with statewide training requirements.
- Provide ongoing training about time management skills for case managers.
- Develop an interagency technical assistance network for case managers.

Cross-Cutting Barriers and Gaps

The following gaps and barriers were identified as being common across two or more of the six service areas. Two categories of barriers and gaps are described: 1) client-related factors include characteristics of clients that impeded access to care and 2) care system-related factors include characteristics of the care system that impeded access to care. Addressing these issues can have far reaching impacts on meeting the needs of PLWHA in care.

Client-Related Barriers and Gaps

- Mental health and substance abuse problems impact clients' access to and compliance with many types of services.
- Lack of transportation impacts access to and compliance with many types of services for PLWHA, especially in rural areas.
- Lack of housing along the continuum of housing needs hinders clients' ability to access and comply with HIV-related services and treatment.
- Clients do not fully comply with service providers' treatment and referrals, may have unrealistic expectations of what service providers can offer, and sometimes do not fully understand providers' roles in addressing client needs.

Care-System Related Barriers and Gaps

- Providers of HIV and non-HIV related services are not sufficiently knowledgeable about the six core service areas and their interrelated role in addressing the needs of PLWHA.
- Insufficient resources for mental health and substance abuse services make it difficult to address these client needs that, in turn, impact access to and compliance with many types of services.
- Limited funding for HIV services creates a climate of competition for resources and clients fostering agency turfisim and hindering true collaboration among agencies, service providers, and other stakeholders.
- Stigma about HIV, mental health, and substance abuse impact the availability and accessibility of services as well as clients' willingness to comply with treatment.
- Limited community resources to develop client life skills and capacities (e.g., job training) hamper efforts to comprehensively address clients' needs that are prerequisite to their ability to access and comply with HIV-related services and treatment.
- Opportunities for peer involvement in meeting the needs of PLWHA are not maximized because peers are underutilized as adjunct service providers, may not be appropriately matched to opportunities to be involved, and their involvement is not always respected.
- Insufficient attention is given to addressing policy level changes that can have far reaching affects on the availability and accessibility of services for PLWHA.

III. PLWHA Not in Care

This section focuses on PLWHA who are out of care. Two categories of barriers and gaps are described: 1) client-related factors include characteristics of clients that impeded access to care and 2) care system-related factors include characteristics of the care system that impeded access to care. This section concludes with strategies for addressing these barriers and gaps with the goal of reducing the number of PLWHA who are out of care.

Barriers and Gaps

Client-Related Barriers and Gaps

- Substance abuse and mental health problems
- Competing priorities, poverty, and homelessness
- Denial among clients about their HIV status
- Depression with feelings of helplessness and hopelessness
- Distrust of providers (e.g., conspiracy theories about HIV)
- Asymptomatic clients may not feel compelled to seek services
- Belief that religion or other "therapies" will heal them
- Attitude of fatalism because there is no cure
- Fear of breaches in confidentiality
- Not wanting to disclose status to partner
- Fear of losing kids or being deported for undocumented individuals
- Client not understanding the difference between HIV, AIDS, and disease management
- Clients not knowing where to go for help
- Language barriers and health illiteracy

Care-System Related Barriers and Gaps

- Lack of transportation to services
- Stigma about HIV among providers and community at large
- Bad first experience with the care system during post-test counseling or DIS contact
- Poor linkages between receiving a positive test and referral for services
- Poor linkages between jail discharge and the HIV care service system
- Long waiting times for appointments or in waiting room
- Experiences of being treated with disrespect by providers or other agency staff
- Side effect of medications

Strategies

Three categories of strategies are described: 1) care system-related strategies describe changes to the system of care, 2) peer-related strategies list approaches that involve PLWHA peers, and 3) community-related strategies include solutions that target the community at large.

Care System-Related Strategies

- Reduce opportunities for clients to drop out of the care system by utilizing rapid testing to minimize the time between taking an HIV test, learning serostatus, and receiving appropriate referrals.
- Provide ongoing, effective, and realistic cultural competency training for all providers and support staff.
- Develop programs that strengthen communication and empowerment skills for clients such as how to ask questions of doctors during medical care visits.
- Strengthen collaboration across all Ryan White funded programs to reduce duplication of services and address gaps.
- Integrate HIV services into a holistic system of care that addresses all aspects of clients' medical and social needs.

Peer-Related Strategies

- Establish a peer volunteer program to enhance cultural competence and rapport between clients and the care system and to support linkages from diagnosis to care through the provision of emotional and practical support (e.g., transportation, child care, accompanying to appointments).
- Identify clients at risk for loss of care and implement intense peer case management strategies to maintain them in the care service system.
- Utilize peers to conduct outreach to identify persons who dropped out of care and to recruit them back into the care service system.

Community-Related Strategies

- Proactively market HIV services, especially in rural areas, through churches, presentations, trainings, and peer volunteers to increase provider, PLWHA, and community awareness of services.
- Involve pastors and the faith community in HIV prevention, testing, and care efforts.
- Engage the political leadership and other influential stakeholders in conveying messages to the community about the severity of HIV epidemic and the need to respond appropriately.